

# EXHIBIT

## 8

**KING**  
**VS.**  
**PARKER, et al.**

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**JAMES WILLIAMS, M.D., M.SC.**

**January 04, 2022**



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1                   IN THE UNITED STATES DISTRICT COURT  
2                   FOR THE MIDDLE DISTRICT OF TENNESSEE  
3                   AT NASHVILLE

4                   TERRY LYNN KING,

5                   PLAINTIFF,

6                   VS.

7                   TONY PARKER, et al.,

8                   DEFENDANTS.

CAPITAL CASE

CASE NO. 3:18-cv-01234

JUDGE CAMPBELL

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12  
13                   Videoconference Deposition of:

14                   JAMES S. WILLIAMS, M.D., M.Sc.

15                   Taken on behalf of the Defendants  
16                   January 4, 2022

17                   Commencing at 10:04 a.m.

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19  
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22  
23                   Elite-Brentwood Reporting Services  
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I N D E X

	Page
Examination By Mr. Mitchell	5

E X H I B I T S

	Page
Exhibit No. 1 Notice of Deposition with Subpoena	7
Exhibit No. 2 Curriculum Vitae and Report of Dr. Williams	43
Exhibit No. 3 Dr. Fackler "Gunshot Review"	100
Exhibit No. 4 Utah's Protocol for Execution by Firing Squad	101
Exhibit No. 5 U.S. Army's Protocol for Execution by Firing Squad	101
Exhibit No. 6 Dr. Young's "Diagnosis of Brain Death"	109
Exhibit No. 7 ATLS Tenth Edition "Advanced Trauma Life Support" Student Manual	123
Exhibit No. 8 U.S. Army Correction System Procedures for Military Executions	128
Exhibit No. 9 E-mail Forum	132

1  
2 S T I P U L A T I O N S  
3

4 The deposition of JAMES WILLIAMS, M.D., M.Sc.,  
5 was taken by counsel for the Defendants, by agreement, via  
6 videoconference, on January 4, 2022, for all purposes  
7 under the Tennessee Rules of Civil Procedure.

8 All formalities as to caption, notice, statement  
9 of appearance, et cetera, are waived. All objections,  
10 except as to the form of the question, are reserved to the  
11 hearing, and that said deposition may be read and used in  
12 evidence in said cause of action in any trial thereon or  
13 any proceeding herein.

14 It is agreed that MELINDA CANTRELL, RPR,  
15 Licensed Court Reporter for the State of Tennessee, may  
16 swear the witness, and that the reading and signing of the  
17 completed deposition was not discussed.  
18  
19  
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22  
23  
24  
25

\* \* \*

MR. MITCHELL: Good morning, Dr. Williams.

My name is Rob Mitchell and I'm with the Tennessee  
Attorney General's Office.

THE WITNESS: Nice to meet you.

MR. MITCHELL: Is there any preliminaries, Lynne, on your end, or Dr. Williams or Ms. Court Reporter?

THE COURT REPORTER: I would like everybody to introduce themselves for the record, once we get started.

MR. MITCHELL: Okay. Yeah.

THE COURT REPORTER: Yeah.

MR. MITCHELL: If there's nothing on your-all's end, I think we can go ahead and swear the witness.

\* \* \*

MR. MITCHELL: Good morning, Dr. Williams. I know we introduced ourselves, but I'm Rob Mitchell on behalf of the defendant in this case. With me today, also appearing by Zoom, are several of my co-counsel: Scott Sutherland, Cody Brandon, and Dean Atyia.

THE WITNESS: Good morning.

MS. LEONARD: Good morning. My name is Lynne Leonard. I represent the plaintiff, Terry King, in this case. And along with me on the Zoom call are several of

1 my colleagues as well. From the Federal Community  
2 Defender Office in Philadelphia is Alex Kursman, Ana  
3 Baldrige, and one of our interns, our fellow, is observing  
4 us, Jules Welsh. And then we have some of my colleagues  
5 from the law firm Bass, Berry & Sims in Nashville,  
6 Tennessee, and that would be David Esquivel and Jeremy  
7 Gunn.

8 \* \* \*

9 JAMES WILLIAMS, M.D., M.Sc.,  
10 was called as a witness, and after having been duly sworn,  
11 testified as follows:

12 EXAMINATION

13 QUESTIONS BY MR. MITCHELL:

14 Q. Where are you located right now, Dr. Williams?

15 A. I live -- I'm in my home in Clyde, Texas.

16 Q. Okay. And what is that address?

17 A. My address is 5260 County Road 120, Clyde, Texas.  
18 C-L-Y-D-E.

19 Q. And is anyone in the room with you, Dr. Williams?

20 A. No. I'm by myself today.

21 Q. Okay. And have you given a deposition before?

22 A. Yes, sir, I have.

23 Q. Okay. How many times?

24 A. Probably in the nature of 15 to 20 depositions  
25 over my career.



1 Q. Okay. And what is that in front of you that's not  
2 your breakfast?

3 A. What's in front of me that's not my breakfast? My  
4 computer.

5 Q. Okay. Anything else?

6 A. And orange juice. I have a notepad and I have my  
7 cell phone, which is not on.

8 Q. Okay. And do you have your expert report or any  
9 other documents in front of you?

10 A. My expert report I have on my computer in front of  
11 me. That's it. I don't have any printed documents.

12 Q. Okay. And do you have anything else on your  
13 computer in front of you that is open?

14 A. No, just the Zoom meeting.

15 Q. And a couple of ground rules I would like to go  
16 over before we begin, Dr. Williams. I know you've taken a  
17 deposition before. Please ask me to repeat if you didn't  
18 hear what I've said, especially since we're over Zoom.  
19 Please ask me to clarify --

20 A. Certainly, I will.

21 Q. I'm sorry, what was that?

22 A. I said, certainly, I will.

23 Q. Thank you.

24 All right. Please ask me to clarify if I say  
25 something and you don't understand what I ask. And you

1       probably know this; breaks are fine. You just can't take  
2       a break between me asking a question and you answering.

3       Can we agree to that?

4       A.       We can.

5       Q.       Okay. Thank you.

6       I'd like to show you -- just one second.

7               MR. MITCHELL: Is the screen share function  
8       available? Oh, there it is. Okay. I'm sorry.

9       BY MR. MITCHELL:

10      Q.       I'd like to show you, Dr. Williams, Exhibit 1.

11               (WHEREUPON, a document was marked as Exhibit  
12      Number 1.)

13      BY MR. MITCHELL:

14      Q.       Do you recognize this document?

15      A.       I'm not seeing a screen share here.

16      Q.       Okay. Do you see this now?

17      A.       Yes, I do.

18      Q.       Okay. And have you seen this document before?

19      A.       Yes, I have.

20      Q.       Okay. And is this a Notice of Subpoena for your  
21      deposition today?

22      A.       I believe it is, yes.

23      Q.       And also to produce documents?

24      A.       Yes, sir.

25      Q.       Okay. And did you produce documents to your

1 attorney?

2 A. I produced documents to my attorney in conjunction  
3 with their advice, yeah.

4 Q. Okay. And what documents did you produce to your  
5 attorney?

6 A. I don't have the list in front of me. Along with  
7 my deposition, I provided the list of my sources that I  
8 used in preparing the -- the report. They have copies of  
9 my Curriculum Vitae, my bona fides, and so forth.

10 Q. Okay. Did you also produce the documents that are  
11 listed in this Attachment A to the subpoena?

12 A. Some of them I did not.

13 Q. Okay. Did you produce your entire file in this  
14 litigation?

15 A. Well, yes, I guess I did. I don't have the paper  
16 file. I have documents on my computer that are at  
17 different locations, e-mails and so forth. I suppose you  
18 could say that constitutes a file, but that's it.

19 Q. Did you produce those e-mails to your attorney?

20 A. Since they're between myself and my attorney, they  
21 have them, yes.

22 Q. Okay. And did you produce all documents and  
23 communications regarding this litigation to your attorney?

24 A. Since all the communications are with my attorney,  
25 yes.

1 Q. So you have no communications regarding this case  
2 that aren't with your attorney?

3 A. Correct.

4 Q. Okay. Did you complete -- or did you provide your  
5 attorneys with time and billing records?

6 A. I have not done so yet, no.

7 Q. Okay. And did you provide your attorneys with all  
8 documents and communications that you cited or relied on  
9 in drafting your expert report?

10 A. Yes, I did.

11 Q. Including any documents that you did not rely  
12 upon?

13 A. Documents I did not rely upon? Well, that would,  
14 you know, be the entire Alexandria Library, so I did not  
15 give them that, no.

16 Q. Are there any documents you reviewed in  
17 preparation for your expert report but ultimately chose  
18 not to rely upon, when submitting your expert report?

19 A. There would be a -- the short answer is yes.

20 Q. Okay. What are those documents?

21 A. My library. I have read hundreds of books and  
22 papers on issues of the death penalty and then the medical  
23 issues related thereto. Essentially, it's a topic that  
24 I've been studying, to some degree, at least ten to  
25 15 years, so there's a tremendous amount of material, most

1 of which is not actually in my possession; library --  
2 library searches, Medline searches, online searches of  
3 documents relating to the medical -- medical aspects  
4 of -- of inflicting death through various means, and these  
5 are -- these are -- it's an enormous compendium of sources  
6 that I've read.

7 Q. Are there documents in your possession that have  
8 influenced your testimony today that you did not provide  
9 to your attorneys in this litigation?

10 A. Not that I'm aware of.

11 Q. And have you provided to your attorneys all  
12 documents and communications showing that you are  
13 sufficiently qualified to testify an expert -- as an  
14 expert in this case?

15 A. I believe they have received all those documents,  
16 yes.

17 Q. Did you rely on any documents or communications  
18 prepared by other experts that influenced your testimony  
19 today?

20 A. Not in the -- not in the preparation of my  
21 document. But since that document was written, I have  
22 been in communication with a -- I attended the trial of a  
23 -- a gentleman on trial -- sorry, on death row in Nevada.  
24 So I did have access to information at that trial that I  
25 haven't had prior to this, and so that -- that does,

1 necessarily, play into my -- my testimony today, uh-huh.

2 Q. And what is the name of that man in Nevada?

3 A. It's not Mr. Floyd, is it? I'm sorry, I don't  
4 tend to keep these names foremost my mind.

5 Q. And are you looking at anything, Dr. Williams?

6 A. I'm looking at my screen to try and minimize this  
7 so I can bring up the file from Nevada.

8 Q. And I'm going to -- I'm going to request that you  
9 don't look at anything other than what I show you during  
10 the course of this deposition.

11 A. Okay. Fair enough.

12 Q. Do you remember --

13 A. I don't recall the -- I don't recall the  
14 plaintiff's name, no.

15 Q. What was it in that Nevada litigation that  
16 subsequently came to your attention that will affect your  
17 testimony today?

18 A. Well, it may affect my testimony. I had  
19 discussions with two of my colleagues, Dr. Zivot and the  
20 other gentleman, I -- his name escapes me as well. And I  
21 must be -- I must be clear here, Mr. Mitchell, I have  
22 developed a lifelong habit of not remembering names. As  
23 an ER physician, I try to remember the details of the  
24 patient.

25 The joke that I make is that if you don't have a

1 name tag or toe tag, I don't know who you are. This is,  
2 in part, a habit in perfecting patient confidentiality.  
3 But I've always been rather absent-minded when it comes to  
4 names, so I don't recall names real well.

5 Nonetheless, Dr. Zivot gave testimony at the trial  
6 in Nevada, which I'm sure you've read about the -- some of  
7 the problems related to execution by lethal injection. He  
8 brought up some points that I had not considered before  
9 just by having quite a lot of reading on the topic of  
10 execution by lethal injection.

11 And he also brought up some facts, not just  
12 arguments, but facts that I was not aware of -- in terms  
13 of the history of lethal injection that I was not aware  
14 of. Those, necessarily, colored my view of executions and  
15 the practicality and efficacy of them. But they don't --  
16 they don't color my testimony on the -- on the facts that  
17 I'm being asked to be an expert on, which is death by  
18 gunshot wound and firing squad.

19 Q. What sort of expert is Dr. Zivot?

20 A. Dr. Zivot is an intensive care specialist. I  
21 believe his -- his board certification is anesthesiology.

22 Q. After Dr. Zivot testified in Nevada, how did your  
23 opinion regarding executions change?

24 A. My general opinion did not change at all. My  
25 concern as to the reliability of execution by lethal

1 injection was raised somewhat. But I've already been  
2 fairly skeptical in some aspects of the efficacy and  
3 efficiency of death by lethal injection already, so I  
4 wouldn't say it substantially changed my views.

5 Q. Did Dr. Zivot's testimony change your views  
6 regarding execution by firing squad?

7 A. Not at all.

8 Q. And what sort of expert was the other Nevada  
9 expert who affected your testimony today?

10 A. The name that comes to my mind is Dr. Freeman, but  
11 I think I've got that wrong. I think I'm confusing him  
12 with another fellow from a different situation. He was  
13 also an anesthesiologist, and he was testifying, again, on  
14 the issues of -- specifically to the pharmacology and  
15 pharmacokinetics of the drugs -- some of the particular  
16 drugs being proposed for death by lethal injection in  
17 Nevada.

18 Q. Dr. Williams, are you under the influence of  
19 anything today, including any medications, that could  
20 hinder your ability to testify truthfully?

21 A. I am not.

22 Q. Do you have any medical condition that could  
23 affect your testimony today?

24 A. I do not.

25 Q. Did you speak to anyone to prepare for your



1 testimony today?

2 A. I spoke with the attorneys for the case, for  
3 Mr. King.

4 Q. Which attorneys were those?

5 A. I spoke with Alex Kursman, Lynne Leonard, I  
6 believe it was Mr. Esquivel. There were three people on  
7 the call last night.

8 Q. Okay.

9 A. And I've had extensive --

10 Q. And --

11 A. -- communication with Alex Kursman and Lynne  
12 Leonard over the past couple of weeks.

13 Q. Were those other communications that were not the  
14 call last night phone, e-mails, Teams? What medium was  
15 used?

16 A. Cell phone calls, primarily, and -- I should say  
17 e-mails, primarily, with some telephone calls to clarify  
18 certain points.

19 Q. And were those all after you submitted your expert  
20 report in this case?

21 A. Well, in terms of preparation for deposition, yes.

22 Q. How many times did you speak on the telephone with  
23 Mr. Kursman?

24 A. Yesterday, I spoke with him twice. Prior to that,  
25 I think I've spoken to him once this year. And before

1 that, it was four to six months since I spoke with him.

2 Q. This year being 2022?

3 A. In 2022, yeah.

4 Q. And how many times -- was Ms. Leonard on all of  
5 those calls?

6 A. No. No. There have been a couple of calls with  
7 just Mr. Kursman and myself and a couple of calls with  
8 Ms. Leonard and myself.

9 Q. How many calls have you had, since submitting your  
10 report, with just Ms. Leonard?

11 A. Two or three, maybe. Actually, it may not be even  
12 that many. It might've been just one or two.

13 Q. Other than your attorneys, did you speak with  
14 anyone to prepare for your testimony today?

15 A. I did not.

16 Q. Did your attorneys read anything to you in  
17 preparation for your testimony today?

18 A. No, I don't recall them reading anything to me.

19 Q. Did you review any documents to prepare for your  
20 testimony today?

21 A. Yes. I reviewed my reports. I reviewed your  
22 subpoena. I reviewed -- with respect to this case? I  
23 reviewed -- yes, I reviewed some materials in -- in  
24 preparation for this case. I reviewed Dr. Lee's expert  
25 report, which you submitted, and I reviewed some of the

1 documents that he had cited, as well as some other  
2 supporting documents that colored my response to that.

3 Q. What supporting documents were those?

4 A. Primarily, his would be -- well, it was Vincent --  
5 Dr. Vincent Di Maio's book, "Gunshot Wounds," which I'm  
6 sure you're familiar with. And in addition to that, a  
7 couple of references that Dr. Di Maio makes, which are  
8 academic papers, which I have looked up online.

9 Q. Academic papers that Dr. Di Maio referenced, but  
10 did not author?

11 A. Correct.

12 Q. What are those academic papers?

13 A. Well, I could get the file out and seek through  
14 it, but there are -- I couldn't name them off the top of  
15 my head. But I did -- I have -- in specific, I looked at  
16 a couple of papers written by Dr. Fack -- Dr. Martin  
17 Fackler, late -- the late Dr. Fackler, who's arguably the  
18 dean of wound ballistics and the foremost expert in  
19 gunshot wound ballistics and gunshot wounding who's ever  
20 lived.

21 So I've reviewed a number of Dr. Fackler's papers,  
22 including the review paper, which I provided to my  
23 attorneys, which is -- which is a very good starting  
24 point. Dr. Di Maio did rely on that in preparing his  
25 book, and it does have some bearing on his -- on Dr. Lee's

1 comment.

2 Q. What other papers of Dr. Fackler did you review in  
3 anticipation of your testimony today?

4 A. I couldn't name them for you. I've got almost  
5 every paper that Dr. Fackler ever wrote in my files.  
6 Unfortunately, I don't have most of those files with me.  
7 We recently moved house and most of my files and books are  
8 in a storage unit. But I've read several hundred papers  
9 by Dr. Fackler.

10 Q. How many papers by Dr. Fackler have you read  
11 Di Maio's the last eight weeks?

12 A. Three or four. And I didn't read them  
13 cover -- you know, beginning to end. I just read the  
14 relevant portions that I wanted to refresh my memory on.

15 Q. In anticipation of your testimony today?

16 A. In anticipation of testimony here, as well as in  
17 preparation of another report for a different case. And  
18 for review for my testimony in Nevada in November, I  
19 reread a couple of Dr. Fackler's points as well.

20 Q. And what report were you preparing for a different  
21 case?

22 A. I've been preparing a report for the Pizzuto case  
23 in Idaho. In Mr. Floyd's case, I've reviewed my report  
24 for the Floyd case again, and that's -- going over my  
25 testimony in my head, so I wanted to review some of the

1 points I made to be sure that I had my facts correct, so  
2 that would primarily be it.

3 Q. Besides documents by Dr. Fackler and Dr. Di Maio,  
4 what other documents did you review in anticipation of  
5 your testimony today?

6 A. You have them in the list of references that I  
7 gave you. I looked at Lieutenant Colonel Grossman's  
8 books, "On Killing," "On Combat," on some issues. I did  
9 also look at -- what else did I look at? Did I look at --  
10 I looked at a couple of anatomic texts, anatomy text books  
11 that I got for refreshers, in my mind, of some details of  
12 anatomy that probably -- that would be about the sum total  
13 of sources that I looked at.

14 Q. Any other sources you reviewed in anticipation of  
15 your testimony today that we have not discussed?

16 A. None that I can think of, sir.

17 Q. What were those anatomy textbooks that you  
18 reviewed?

19 A. One of them is -- the one that I relied mainly on  
20 is "Grant's Atlas of Anatomy," which is a common --  
21 commonly reviewed source, and I can't recall the name of  
22 the other one. It's a photographic anatomy atlas out of  
23 the University of Cambridge. I've got a pocket copy of it  
24 that's very helpful.

25 Q. Besides that, did you review anything else in

1 anticipation of your testimony today?

2 A. Nothing that I can recall.

3 Q. Dr. Williams, where did you attend high school?

4 A. I attended high school at William Aberhart High  
5 School in Calgary, Alberta, Canada.

6 Q. And after high school, did you go to college?

7 A. I went to the university at the University of  
8 Calgary. I obtained a bachelor's degree in zoology.

9 Q. Okay. And what year was that?

10 A. I received my bachelor's degree in 1976.

11 Q. And after you received your bachelor's, did you  
12 pursue your education further?

13 A. I pursued another year of university education at  
14 the same institution to obtain a teaching credential so  
15 that I could teach school.

16 Q. And did you pursue your education after that?

17 A. Yes, sir. I taught school for eight years, and  
18 then I returned to the university to enter -- I took a  
19 one-year course of studies to get some grades behind me  
20 because I had been an indifferent student in my bachelor's  
21 program, decided to apply myself, get some good grades so  
22 I could get into graduate school. Did one year of that,  
23 obtained a very high GPA, did some tough courses.

24 And then I proceeded to enter a graduate program  
25 in endocrinology and biochemistry, which I started in 1989

1 -- sorry, 1985 -- wait, no, '86, January of '86. I  
2 entered that program and graduated in September of 1988  
3 with a master's degree in biochemistry and endocrinology.  
4 I also entered, simultaneously -- as I was preparing to  
5 defend my thesis, I was accepted into and began studies at  
6 the University of Calgary. All my degrees are from the  
7 University of Calgary.

8 But before I finished my master's defense, I  
9 entered medical school at the University of Calgary  
10 Cumming School of Medicine and graduated from that  
11 university three years later with a medical degree.

12 Q. When you taught school for eight years, what did  
13 you teach?

14 A. Mostly kids. But I specialized in chemistry and  
15 biology. I did teach some physics and I taught some  
16 mathematics.

17 Q. And what year did you get your MD?

18 A. 1991.

19 Q. And that was from the University of Calgary?

20 A. Yes, sir.

21 Q. Where did you complete your residency?

22 A. At the University of Alberta.

23 Q. And did you have any particular emphasis of study  
24 when you pursued your MD?

25 A. I was very interested in endocrinology and

1       anesthesiology. I actually wanted to be an  
2       anesthesiologist, but I had -- unfortunately, I didn't  
3       have the finances to be able to afford that. I had three  
4       small children, so I took the shortest residency that I  
5       could take, which was family medicine.

6       Q.       And what do you do professionally, Dr. Williams?

7       A.       My primary occupation is as an emergency  
8       physician.

9       Q.       Okay. And how long have you practiced emergency  
10      medicine?

11      A.       I've been -- I was practicing emergency medicine,  
12      part-time, from 1993, when I began in private practice,  
13      until 2003, at which time I became a full-time emergency  
14      physician. In the precedent years, I practiced clinical  
15      family medicine with a -- basically, what we call -- used  
16      to call, in those days, general practice, which meant I  
17      did everything. I did obstetrics, I did surgery, I did  
18      pediatrics, geriatrics, and admitted to hospital, did  
19      hospitalist work, and I also covered the emergency room,  
20      you know, pretty much it.

21      Q.       As an emergency physician, what are your  
22      responsibilities?

23      A.       Well, when -- as the emergency services physician  
24      at any hospital has the responsibility of making the  
25      initial assessment examination and diagnosis of emergent



1 conditions that present to the emergency department,  
2 making appropriate tests and treatment as required, and  
3 then the settling on a disposition, whether discharge back  
4 into the community or admission to the hospital or  
5 transfer to another facility. So it's -- it's a complex  
6 job.

7 Q. Are those your responsibilities?

8 A. Yes, sir.

9 Q. Do you perform trauma-related surgery?

10 A. I do not do surgery in a sense that most people  
11 think of it as surgery. I perform emergency procedures on  
12 some trauma patients, which could be considered  
13 quasi-surgical, such as placement of chest tubes,  
14 which -- excuse me -- thoracostomies, which are procedures  
15 for either draining blood out of the chest or air out of  
16 the chest. I do quasi -- I do surg -- sorry -- venous and  
17 arterial cutdowns on occasion, but my services are  
18 primarily what would be called procedural as opposed to  
19 surgical.

20 Q. So you do not perform what people traditionally  
21 think of a surgery?

22 A. I do not.

23 Q. Where do you practice emergency medicine?

24 A. My primary place of practice, right now, is at  
25 Citizens Hospital in Victoria, Texas. I have a couple of

1 other hospitals that I do some part-time practice at;  
2 Pecos, which is Reeves County Hospital in Reeves County in  
3 West Texas, Saint Francis Hospital in Grand Island,  
4 Nebraska, and I also have privileges in a couple of  
5 hospitals in Wisconsin, but I don't practice there at this  
6 point.

7 Q. Are you an independent contractor at all of these  
8 hospitals?

9 A. I am.

10 Q. You said that being an emergency services  
11 physician is your primary job; is that correct?

12 A. That's correct.

13 Q. What other occupations do you have?

14 A. I have a clinic at -- two clinics, actually, one  
15 in Kingsville, Texas, and one in Abilene, Texas, which is  
16 very close to me here, where I do --

17 Q. What are the names of those clinics?

18 A. The name of my clinic is a PLLC called Anahata  
19 Wellness Center, and I specialize there in treatments for  
20 hormone replacement for men and women, as well as some  
21 minor cosmetic procedures, such as injections, fillers,  
22 and neurotoxins for cosmetic purposes.

23 Q. And do you have any other occupations other than  
24 those that we discussed?

25 A. I do conduct firearms training under the -- my

1 other company. My LLC is called Tactical Anatomy Systems,  
2 LLC. I conduct training for civilian, but primarily law  
3 enforcement personnel, in the use of deadly force.

4 Q. Do you own Tactical Anatomy Systems?

5 A. I do.

6 Q. Are there any other employees of Tactical Anatomy  
7 Systems?

8 A. There are not.

9 Q. Have there ever been any other employees?

10 A. No.

11 Q. How long have you operated Tactical Anatomy  
12 Systems?

13 A. I believe I incorporated Tactical Anatomy in '05  
14 or '06. I'd have to look at the articles of  
15 incorporation. I was teaching that same material for  
16 about three years prior to incorporation.

17 Q. Does Tactical Anatomy have a website?

18 A. Yes.

19 Q. And is Tactical Anatomy incorporated in Texas?

20 A. It's incorporated in Wisconsin.

21 Q. Now, have you ever served as a SWAT team  
22 physician?

23 A. I have.

24 Q. For how long? How many years?

25 A. It was about -- I was on the -- on the SWAT team

1 for about two years.

2 Q. And were you on the SWAT team as a physician?

3 A. Yes.

4 Q. What were your duties as a SWAT team physician?

5 A. Primarily to provide consultation and instruction  
6 to the team members and to the administration of the  
7 sheriff's department, formulate medical care policies for  
8 the SWAT environment, to train the SWAT team members on  
9 principles of tactical combat casualty care, T3C, and to  
10 attend SWAT operations when it was feasible to do so, and  
11 attend as a fully functioning member of the SWAT team to  
12 provide oversight of care of any casualties that may occur  
13 at the SWAT operation.

14 Q. As a SWAT team physician, did you treat gunshot  
15 wounds?

16 A. I fortunately never had to treat a gunshot wound  
17 as -- as the team physician. I did treat some gunshot  
18 wounds that came from that same department, but I was not  
19 on those operations, and I treated them in the emergency  
20 department where I was on duty at the time.

21 Q. Did you perform surgery related to those gunshot  
22 wounds?

23 A. No. I do not perform surgery, as I previously  
24 testified.

25 Q. Do you have any other current medical employment?

1 A. I do not.

2 Q. Are you board certified, Dr. Williams?

3 A. I am board certified.

4 Q. By whom are you board certified?

5 A. I am certified by the American Board of Family  
6 Medicine.

7 Q. And how long have you been board certified by the  
8 American Board of Family Medicine?

9 A. Since 2008.

10 Q. And are you board certified by any other  
11 associations?

12 A. Yeah. I maintain -- it's not called board  
13 certification, but it's the equivalent in Canada. I'm  
14 certified by the College of Family Physicians of Canada.

15 Q. And how long have you been certified by the  
16 College of Family Physicians of Canada?

17 A. Since 2003. Sorry, 19 -- 19 -- 1993. I  
18 apologize, getting my decades mixed up.

19 Q. Do you belong to any professional associations,  
20 Dr. Williams?

21 A. I belong to the Texas -- Texas Medical  
22 Association, TMA. Am I still on -- I think I'm still a  
23 member of the American College of Sports Medicine, but  
24 I -- I'm really not very active with that, so I can't  
25 recall. I think my dues --

1 Q. Do you --

2 A. -- may have lapsed.

3 Q. Do you have an active membership in any other  
4 professional associations?

5 A. No, I do not.

6 Q. Do you consider yourself an expert in firearms,  
7 Dr. Williams?

8 A. Yes, I do, in some firearms.

9 Q. And what -- which firearms?

10 A. Primarily pistol, handguns.

11 Q. Do you consider yourself an expert in rifles?

12 A. I consider myself less expert, but I am certified  
13 as such, yes.

14 Q. By whom are you certified?

15 A. National Rifle Association.

16 Q. And --

17 A. I --

18 Q. Do you --

19 A. I also have expert -- I also have held expert  
20 qualification in rifle by the Department of Justice in the  
21 State of Wisconsin and by the sheriff's department in  
22 that -- that I served at. So I have expertise there, yes,  
23 in rifle.

24 Q. And on what basis do you consider yourself an  
25 expert in riflery?

1 A. On the basis of having been a lifelong rifle  
2 shooter, of being a life -- not a lifelong competitor, but  
3 I've been an active competitor in rifle competition and  
4 tend to place quite highly. I have been qualified as a  
5 sharpshooter under NRA guideline for qualification. I  
6 qualified as expert with my sheriff's department in  
7 Wisconsin. So those things would say that I'm an expert.

8 Q. Are there any other bases that lead you to  
9 consider yourself an expert in riflery?

10 A. Not any that you could point a finger at and say  
11 this is my certificate in it. But, no, having the amount  
12 of experience I have in the use of rifles, in competitive  
13 marksmanship, and in hunting, as well as in tactical  
14 training, these things would all speak to my expertise.

15 Q. Do you teach tactical training with the use of a  
16 rifle?

17 A. I do.

18 Q. And what does that training consist of?

19 A. It -- it varies. Most of my training is classroom  
20 training within the -- the Tactical Anatomy curriculum.  
21 But we do some training with police car beams; rifles in  
22 shot placement, under time and space to rest to -- the  
23 objective being to get the officers that I'm training to  
24 be able to place their shots more precisely for definitive  
25 incapacitation of their adversary, in the shortest

1 possible time.

2 Q. Is the focus of this rifle training how to aim a  
3 rifle?

4 A. I would say that's intrinsic in the training, but  
5 I don't teach people how to form a safe picture. When  
6 people come to me for my training, they are already --  
7 they must already be operating at a fairly high level of  
8 proficiency with their firearms. In other words, they  
9 must be able to pass their department's qualification  
10 course of fire with pistol, rifle, and shotgun adequately  
11 -- and be expert enough with their own weaponry that they  
12 know how to aim themselves, without me having to teach  
13 them such a basis skill. I simply refine their ability to  
14 aim their rifle in such a way that it can produce a better  
15 outcome in an officer-involved shooting.

16 Q. Is it fair to say you teach them where to aim  
17 their rifle?

18 A. That would be fair.

19 Q. On what basis do you consider yourself an expert  
20 in handguns?

21 A. I have considerably more competition experience in  
22 handguns and considerably more training and -- and  
23 qualifications as a handgun instructor. I'm certified as  
24 a pistol instructor by the National Rifle Association.  
25 I'm also certified by SADAA (phonetic) group as a



1 fourth-level instructor.

2 I have -- what else have I got? Wisconsin Pistol  
3 Association did at one time qualify me as an instructor.  
4 I was the area coordinator for the in -- International  
5 Defensive Pistol Association for the State of Wisconsin  
6 for ten years, organizing pistol matches. And I was also  
7 a safety officer instructor for the International  
8 Defensive Pistol Association, in which I instructed the  
9 instructors, telling them how to teach people safe  
10 operation of their firearms in a competition environment.

11 Q. Is this in --

12 A. I'm also certified as a firearms instructor by the  
13 Wisconsin Department of Justice in pistol.

14 Q. Is there any other basis that we have not  
15 discussed upon which you consider yourself an expert in  
16 firearms?

17 A. No, I think we've pretty much covered it.

18 Q. Do you have any other experience that you relied  
19 on, in writing your report in this litigation?

20 A. Well, pretty much it all comes down to my firearms  
21 expertise and my medical expertise, which is a -- an  
22 amalgam of two lifelong bodies of study.

23 Q. Have you ever --

24 A. So that's about it.

25 Q. Have you ever shot a human being, Dr. Williams?

1 A. I have been fortunate not to do so.

2 Q. Have you ever been present when someone other than  
3 yourself received a gunshot wound?

4 A. Yes.

5 Q. How many times?

6 A. Once.

7 Q. Under what circumstances?

8 A. It was in a hospital emergency room where the  
9 individual was shot by a police officer as he was  
10 attempting to carry out an act of deadly force on the  
11 officer.

12 Q. Where was the individual shot?

13 A. In the leg.

14 Q. Did you treat the individual?

15 A. I did.

16 Q. And what year was this?

17 A. Somewhere between 2000 and 2003. I couldn't tell  
18 you the exact year.

19 Q. Have you ever been present when someone was shot  
20 in the chest?

21 A. Other than myself, no.

22 Q. Have you ever been present when someone was shot  
23 in the head?

24 A. No.

25 Q. How many people have you treated were shot in the

1 head?

2 A. Hard to say. Over 100, less than 200, somewhere  
3 in there. I would say 150.

4 Q. How many of those individuals do you estimate died  
5 from that wound to the head?

6 A. I couldn't say with any precision. It would be  
7 probably more than 80 percent.

8 Q. What does your treatment of those individuals  
9 generally consist of?

10 A. Of a head gunshot wound?

11 Q. Yes.

12 A. Well, my initial assessment is going to evaluate  
13 whether the individual is -- is conscious and breathing,  
14 maintaining his own airway. That's my first assessment.  
15 I follow the standard ABCs of trauma: If his airway's  
16 intact, that's good. If he's breathing, that's also good.  
17 Does he appear to have circulatory stability? Are his  
18 hemodynamics stable? Then I have to reassess whether he  
19 has some significant disability such that he's not able to  
20 control his airway. And then, if necessary, secure the  
21 airway by an intratracheal intubation. These are the  
22 emergent things that need to be gone.

23 Then the next -- the next step -- other  
24 than -- after that would be to do a complete survey of the  
25 individual, head-to-toe, to see if there's other wounds,

1 other issues I need to be concerned about. And then as  
2 soon as it's practicable and expedient, I get that  
3 individual to the CT scanner so we can find out what the  
4 heck is going on inside his head, find out where the  
5 bullets have gone, where the wounds are, what the damage  
6 is, and then proceed from there to -- to disposition. Of  
7 course, we obtain lab work as well.

8 But, generally speaking, most of the hospitals  
9 I've worked at, in my career, don't have neurosurgical  
10 capabilities, so that means the patient has to be  
11 transferred to a hospital that does have neurosurgical  
12 capability, unless the individual is already deceased, in  
13 which case transfer is not necessary. But most of the --

14 Q. Do you --

15 A. Most of the time they're transferred to a  
16 neurosurgeon.

17 Q. And you do not perform neurosurgery, do you?

18 A. I do not.

19 Q. Have you ever performed neurosurgery?

20 A. I've been present when neurosurgical  
21 procedures -- been there as an observer and an assistant a  
22 handful of times. Neurosurgery is not something I've  
23 looked into in great depth.

24 Q. But you have not performed neurosurgery yourself?

25 A. Sure have not.

1 Q. Have you ever had anyone come into your emergency  
2 room who had received four bullets to the head and was  
3 still able to return fire, after receiving these wounds?

4 A. Yeah. Yes.

5 Q. When was that?

6 A. That was sometime between 2003 and 2007, somewhere  
7 in there. We had a fellow was drunk in our county and he  
8 decided to -- I don't know what he decided -- but, anyway,  
9 he elected, in the circumstances of a domestic dispute, to  
10 pull a gun and fire upon the two officers, sheriff's  
11 department -- I think it was sheriff -- yeah, they were  
12 sheriff's officers, who were there to -- to intervene in  
13 the domestic situation.

14 The individual was fired upon by the officers and  
15 he was hit four times in the head, none of which were  
16 severe wounds. He was -- they were all peripheral wounds  
17 that affected the skin. One bullet tunneled under the  
18 scalp, both the earlobes were hit -- actually, no, the  
19 fourth bullet didn't hit his head, it hit his neck.  
20 Again, was a superficial wound.

21 All four wounds were superficial and the  
22 individual survived by treating in the emergency room with  
23 basic -- basic care, and then he was transferred to jail.

24 Q. And was the individual able to return fire on the  
25 officers, after receiving these four gunshot wounds to the

1 head?

2 A. I don't know whether he did or did not. But he  
3 was certainly capable of doing it, yes. He was conscious.  
4 He was alert. He was able to -- his judgment was intact.  
5 He was able to speak and answer questions. He had full  
6 use of all of his facilities, although he was intoxicated.

7 Q. Do you agree that there is a huge potential for a  
8 variant in outcomes, when someone is shot in the head?

9 A. Of course.

10 Q. Is one of those reasons for the potential for  
11 variance because the brain stem is very small?

12 A. That would be fairly low on my list of primary,  
13 but yeah, that's certainly true.

14 Q. Are you reviewing anything in front of you,  
15 Dr. Williams?

16 A. No, I'm just doodling.

17 Q. Can the brain stem be difficult to hit because it  
18 is small?

19 A. Any small target's hard to hit, sir.

20 Q. Including the brain stem?

21 A. Of course.

22 Q. Can the brain stem be difficult to hit because of  
23 the density of the bones in the skull?

24 A. Well, no. Hitting the brain stem with a bullet is  
25 a matter of firearms accuracy, and it's not really -- no,

1 no. The bones -- the density of the bones and skull are  
2 less of a concern than where you're actually aiming your  
3 bullet.

4 Even a .22-caliber bullet, a .22 rimfire, has  
5 enough energy to penetrate from any angle, provided the  
6 angle is -- is aimed precisely. It requires a  
7 perpendicular or nearly perpendicular of the bullet on the  
8 portion of the skull that your bullet has to pass through.  
9 If it's a tangent past a certain amount, 30 degrees, 45  
10 degrees -- I couldn't tell you the precise angle -- once  
11 the angle of incidence is tangential enough, it will not  
12 penetrate the bone, but it will glance off and on to the  
13 scalp.

14 Q. So is it your testimony, Dr. Williams, that the  
15 density of the bones do not make it more difficult to hit  
16 the brain stem with a bullet?

17 A. In sum and in short, yes, that's true.

18 Q. Does the curvature of the skull's surface make it  
19 difficult to hit the brain stem?

20 A. It can be. It can be. If -- well, no, actually,  
21 it doesn't make it difficult to hit the brain stem at all  
22 because if you're aiming at the brain stem from any angle,  
23 you're not going to have to deal with -- with curvature of  
24 the skull because you'll be aiming at, virtually, a  
25 perpendicular angle; any presentation, 360, 360. XY is

1 the axis.

2 Q. Is it well documented in trauma literature that  
3 pistol bullets striking the human head at certain angles  
4 will glance off the bone of the skull and exit without  
5 penetrating the skull?

6 A. Yes.

7 Q. What trauma literature is that?

8 A. The medical trauma literature. I mean, you can  
9 read the articles to that nature in Journal of Trauma,  
10 Annals of Emergency Medicine, you name it. I'm sure you  
11 could find it in virtually all of the skull-related  
12 journals. Medical journals, trauma journals, you'll find  
13 reports on this type. It's just --

14 Q. Do you --

15 A. Okay.

16 Q. Do you know the names of any of those reports?

17 A. No, I don't have them at the top of my head.

18 Q. Do you know the names of any of those authors?

19 A. Many of them I will know if I looked at them, but  
20 no, I couldn't tell you one off the top of my head.

21 Q. Do you agree that with a random gunshot to the  
22 head, the chances of hitting the brain stem are 6 to  
23 7 percent?

24 MS. LEONARD: Object to the form.

25 You can answer, Dr. Williams.



1 THE WITNESS: Oh, okay.

2 I couldn't tell you whether it's 6 to  
3 7 percent, 15 percent, 30 percent. I've never seen that  
4 particular statistic, so I don't have an opinion on it.

5 BY MR. MITCHELL:

6 Q. So, in your opinion, it could be as much as  
7 30 percent that a random shot to the head could hit the  
8 brain stem?

9 MS. LEONARD: Object to the form.

10 THE WITNESS: I'm sorry. I didn't answer you  
11 correctly, Mr. Mitchell. My comment was I have no idea  
12 what the percentage might be.

13 BY MR. MITCHELL:

14 Q. How many people have you treated, Dr. Williams,  
15 who were shot in the chest?

16 A. Several hundred.

17 Q. A thousand?

18 A. I don't think that many, but it might be getting  
19 close to it.

20 Q. How many of those individuals died of that gunshot  
21 wound to the chest?

22 A. Again, I don't know because I don't see most  
23 people after they've been through my emergency department.  
24 But my understanding is with -- and depending on the  
25 sources you use for the -- some of the most reliable data

1 that I think I've seen came out of Miami. Wasn't medical.

2 Miami Metro Dade did a study of lethality of  
3 gunshot wounds, and their estimate was that only about 6  
4 percent of gunshot wounds sustained in the field --  
5 handgun, gunshot wounds -- resulted in death. So those  
6 are gunshot wounds anywhere.

7 The people that I see who've been shot in the  
8 chest in the emergency room tend to be people who are  
9 pretty -- pretty badly injured. There are people who  
10 don't even come to the hospital after a gunshot wound, a  
11 very small minority of course. But all of these things  
12 make it difficult to estimate the lethality of a gunshot  
13 wound to the chest.

14 Outside of the central corridor of the chest,  
15 running the -- the middle portion and anterior portion to  
16 your presentation, there's a lot of -- a lot of air.  
17 There's a lot of non -- nonlethal structures that can be  
18 interdicted by a bullet, and they will produce relatively  
19 minor injury only and are very survivable.

20 So if I did a search on that, I could probably  
21 give you an estimate, but I'd say probably the number  
22 of people who die from their gunshot wounds, from their  
23 chest, is probably a minority of the cases and, maybe, as  
24 small as 30 to 40 percent, but I -- that's just a guess.

25 Q. How many rifle wounds to the chest have you

1 treated?

2 A. Quite a few less. Probably -- probably fewer than  
3 200, maybe fewer than 100. I couldn't -- I don't keep  
4 records on these things, so this is just a general  
5 impression of my -- over the course of my career.

6 Q. Have you ever seen anyone die by lethal injection?

7 A. I have not.

8 Q. Have you ever served as an expert for any state  
9 department of corrections?

10 A. I've never testified as an expert for the  
11 department of corrections, no.

12 Q. Do you have any blogs, Dr. Williams?

13 A. Yes, I have a blog that I write, intermittently,  
14 on my website.

15 Q. What blog is that?

16 A. The tactical -- it's the Tactical Anatomy Systems  
17 website and it's just called blog.

18 Q. Do you have any other blogs?

19 A. No.

20 Q. What topics do you write about on that blog?

21 A. Typically, I write about issues of firearms,  
22 ammunition, gunshot wounding, police -- issues of police,  
23 law enforcement officers, and military imports; issues of  
24 the day that affect law enforcement, which, as you may  
25 gather, I'm quite a strong poignant of that -- that lobby.

1 Q. Have you had any other blogs in the past,  
2 Dr. Williams?

3 A. No, I haven't really been a blogger.

4 Q. Are you on any social media?

5 A. Yeah. Yeah, I have a Facebook account, a personal  
6 one, as well as a Facebook account for my -- for Tactical  
7 Anatomy, and another one for Anahata Wellness systems.

8 Q. Do you have any other social media accounts?

9 A. No.

10 Q. Have you had any other social media accounts in  
11 the past?

12 A. I guess if you call -- social media accounts? If  
13 you call being on an Internet message board, yes, I have.  
14 Is that -- is that what you're driving at?

15 Q. Sure. What is that Internet message board?

16 A. Well, there's a bunch of them. I'm a member of a  
17 number of past and present firearms in law enforcement  
18 message boards: 24hourcampfire.com would be one, another  
19 one would be 10-8, that's 10-8forums.com. There's a law  
20 enforcement one called primaryandsecondary.com, ar15.com.  
21 I'm a member on all of these, but I rarely contribute.

22 What's the other one that was -- Dr. Gary Roberts  
23 and I were both very active in Primary and Secondary for a  
24 while on the issue of gunshot wounding and ballistics.  
25 And there's a couple of other wound ballistic pages that I

1 was a member of, for a period of time, but I -- I rarely  
2 go -- excuse me -- I rarely have time to write on or even  
3 read any of those anymore.

4 Q. Do you have a username on 24-Hour Campfire?

5 A. Yeah, it's Doc Rocket.

6 Q. And do you have a username on 10-8 Forums or 10-8?

7 A. I believe it's just my name. James S. Williams,  
8 but it might be JSWMD. I can't recall.

9 Q. Do you have a username on Primary and Secondary?

10 A. Yeah, but I -- again, I haven't been there for a  
11 while. I think it's JSWMD, or it may be James Williams,  
12 MD. I can't recall.

13 Q. Do you have a username on ar15.com?

14 A. I haven't been there -- I must have, but I haven't  
15 been there in so long that I can't recall. I think  
16 it's -- if I have a membership, it's James W, MD or it may  
17 be Doc Rocket. I can't recall.

18 Q. When was the last time you accessed any of these  
19 forums?

20 A. Well, I was doing some COVID education on 24-Hour  
21 Campfire back in the summer, July, August. I usually keep  
22 up with some of the hunting news that the guys have --  
23 some of the guys I know there. I might -- I did check in  
24 on one of the hunting forums in late December briefly, but  
25 that would be it.

1 Q. Did you prepare an expert report in this case,  
2 Dr. Williams?

3 A. I did.

4 Q. I'm going to share my screen.

5 Do you recognize this document, Dr. Williams?

6 A. I do.

7 Q. Is this your expert report in this litigation?

8 A. Yes.

9 Q. And it's dated November 10, 2021?

10 A. Yes, sir.

11 Q. Okay.

12 MR. MITCHELL: I'll have this marked as  
13 Exhibit 2, please.

14 (WHEREUPON, a document was marked as Exhibit  
15 Number 2.

16 BY MR. MITCHELL:

17 Q. And is this your signature on page 14,  
18 Dr. Williams?

19 A. It is.

20 Q. Dr. Williams, what questions were you engaged to  
21 answer?

22 A. I was asked to report on the efficiency, efficacy  
23 of a firing squad as a means of execution.

24 Q. Okay. Do you see right here, on page 4, where it  
25 says you're engaged to address two questions?

1 A. Uh-huh.

2 Q. Are those the two questions you were engaged to  
3 address?

4 A. Those are the specific questions, yes.

5 Q. Is the first question: Would execution by firing  
6 squad cause death in a quick and painless manner?

7 A. Yes, that would be what I would call efficacy.

8 Q. Is the second question: Is execution by firing  
9 squad feasible in Tennessee?

10 A. Yeah. And that's what I would call efficiency,  
11 yes.

12 Q. Were you engaged by plaintiff's counsel to answer  
13 any other questions?

14 A. This is what I was engaged to answer, and these  
15 are the questions I've answered.

16 Q. Were you engaged to address any other methods of  
17 execution?

18 A. I was not.

19 Q. Did plaintiff's counsel engage you to craft a  
20 protocol for execution by firing squad?

21 A. They did not.

22 Q. Have you ever crafted a protocol for execution by  
23 firing squad?

24 A. Absolutely not.

25 Q. Did you attach your CV to this expert report?

1 A. It was submitted, yes.

2 Q. Is your CV up to date in this case?

3 A. It should be. I reviewed it just before  
4 submission, so it would have been up to date at that time.

5 Q. As of November 10th, was this list of expert  
6 reports and testimony up to date?

7 A. Yes.

8 Q. Did you ever testify as an expert in 2021?

9 A. In '21? Yes. I testified as an expert in  
10 deposition in the Glossip case, and I testified in Las  
11 Vegas, Nevada, in the -- the other case that I referred  
12 to, Floyd, the Floyd case.

13 Q. And what month did you testify in the Floyd case?

14 A. I testified around November 18th of 2020.

15 Q. Do you know if it was on November 18th -- of 2020  
16 or 2021?

17 A. Oh, yeah, '21. Sorry, 2021. My bad. If I look  
18 at my calendar, I could tell you exactly what date.

19 Q. Please do that.

20 A. Okay. And I testified on the morning of 18  
21 November.

22 Q. Okay. And when did you testify in the Glossip  
23 case?

24 A. I don't have that date in front of me. Last year,  
25 July -- June, July, something like that. Might have been



1 April or --

2 Q. In 2021 -- I'm sorry, what was that last part?

3 A. I -- no, I'm -- I was just saying I couldn't  
4 remember the month. Go ahead.

5 Q. In 2021, did you testify as an expert in firing  
6 squad in any other litigation?

7 A. I did not testify under any litigation last year  
8 other than those two -- those two circumstances.

9 Q. Did you testify as an expert as to firing squad in  
10 2020?

11 A. Twenty-twenty? I don't believe we had anything in  
12 2020, no.

13 Q. Now, this is a list of your lectures and  
14 conferences that you've presented at?

15 A. Uh-huh.

16 Q. Have you left any lectures and conferences out?

17 A. Uh-huh.

18 Q. Which ones?

19 A. Yes, I have. Many. These -- I just highlighted  
20 the ones that I was an -- I was advertised as a speaker  
21 at.

22 Q. So --

23 A. This -- there's been many other conferences. For  
24 instance, I've attended the IALEFI conference that you'll  
25 see in the first instance, IALEFI. I've attended almost

1 every IALEFI conference since 2009. I missed a couple.  
2 ILEETA, which you can see down there in the fourth, I've  
3 attended the ILEETA conference almost every year since  
4 2007. That's an annual meeting. So I attend, but don't  
5 necessarily present. But I'm often asked to participate  
6 in discussions.

7 And I served on the panel of experts at ILEETA  
8 many years that I've been there. And there's a -- a panel  
9 discussion on the -- one of the afternoons that I lead  
10 where the firearms experts panel, answer questions from  
11 the -- the general membership attending, and we have a  
12 discussion -- a roundtable discussion about issues of the  
13 day affecting firearms and gunshot wounds and so forth.

14 Q. Were you a presenter at any conferences in 2021?

15 A. No.

16 Q. Were you a presenter at any conferences in 2020?

17 A. Yeah. Yeah. I presented at IALEFI in 2020.

18 Which I think is on there; is it not? Oh, no, it wasn't  
19 2020, it was 2018. Time flies. No, 2018 was the last  
20 time I presented at a major law enforcement conference.

21 Q. After that June 2018 law enforcement conference,  
22 have you presented at any other conferences in the  
23 intervening three and a half years?

24 A. I have not.

25 Q. Do you have any certifications related to firing

1 squad?

2 A. Only that I have been accepted as an expert in  
3 firing squad by the State of Arkansas, by the judge of the  
4 State of Arkansas trial, and again here in Nevada. Those  
5 are the only two things that would give me any bona fides,  
6 I guess.

7 Q. Nothing from any sort of professional association?

8 A. Yeah, no, I don't know that there is any  
9 professional firing squad organization, so.

10 Q. Have you undergone any training relating to firing  
11 squads?

12 A. I'm not aware that anyone has ever had any such  
13 training available anywhere in the world.

14 Q. So --

15 A. So no.

16 Q. -- is the answer no?

17 A. So the answer is no.

18 Q. Have you ever spoken to a participant of a firing  
19 squad execution?

20 A. No, I haven't spoken with him. I was present when  
21 he was -- when he testified in Arkansas.

22 Q. Who was that individual?

23 A. It was -- I believe he was the assistant warden.  
24 I can't recall his name. So he was one of the  
25 administrators involved in the last -- I might be mistaken

1 here. Hang -- let me -- hang on a second.

2 I recently saw the deposition of the -- the warden  
3 at the Utah prison, and I might be confusing him with the  
4 other fellow. Let's just say I have -- I think -- I can't  
5 say with certainty that I have -- that there -- that there  
6 was testimony at Arkansas by that individual. I may be  
7 mistaken. I may be confounding two different testimonies.

8 Q. In any event, you haven't spoken personally with  
9 these individuals?

10 A. No, sir, I have not.

11 Q. Now, do you see here, on page 2 of your report,  
12 where you state that you've conducted about ten, quote,  
13 firearms training in the past five years?

14 A. Yeah, I see it.

15 Q. Towards the bottom?

16 A. Yes.

17 Q. When was the last firearms training you conducted?

18 A. I last instructed at a firearms class in October  
19 of 2021. I was an assistant instructor at a class offered  
20 by a colleague. And I last conducted a Tactical Anatomy  
21 -- full Tactical Anatomy course in the state of Nevada in  
22 2019.

23 Q. In 2019, 2020, or 2021, did you conduct any other  
24 firearms training?

25 MS. LEONARD: Object to the form.

1 THE WITNESS: I did not -- I did not conduct  
2 any firearms trainings as a -- as the provider of the  
3 training. I may have provided some ad hoc assistance at  
4 one or two classes that I attended. But, no, I have not  
5 actually been the on-the-spot trainer for any of them. So  
6 that's -- that's the sum right there that we talked about.

7 BY MR. MITCHELL:

8 Q. So you assisted a colleague in October of 2021 in  
9 conducting a firearms training; is that correct?

10 A. Yeah, that's correct.

11 Q. And in 2019, that was the last Tactical Anatomy  
12 Systems firearms training you conducted?

13 A. Yes, sir.

14 Q. And did you only conduct the one Tactical Anatomy  
15 Systems training in the last three years?

16 MS. LEONARD: Object to the form.

17 THE WITNESS: The -- the Nevada class --

18 MR. MITCHELL: Just a second, Doctor.

19 Dr. Williams, let me interrupt you. I'm -- I'm sorry.

20 Lynne --

21 THE WITNESS: Okay.

22 MR. MITCHELL: -- what's the basis for your  
23 objection? Can you explain?

24 MS. LEONARD: Yeah, it's an unclear question.

25 Could you just rephrase that to make that a little -- a

1 little clearer what you're asking?

2 MR. MITCHELL: Sure.

3 BY MR. MITCHELL:

4 Q. Dr. Williams, I apologize. In 2019, did you only  
5 perform one Tactical Anatomy Systems training?

6 A. Actually, no. We already covered the other one.  
7 I conducted the training in Nevada for the Department of  
8 Wildlife, which was, I think, in March. And then I  
9 conducted the training at Houston, which we've already  
10 covered, at the IALEFI conference. So there were actually  
11 two classes that year, but that was the sum total for  
12 2019.

13 Q. How many trainings did you conduct in 2018?

14 A. I would have to review that, but somewhere in the  
15 neighborhood -- three or less. I don't do a lot of  
16 teaching of this stuff anymore.

17 Q. Were those all through Tactical Anatomy Systems?

18 A. Yeah. That's the only -- the only place that I  
19 offer training, yeah, is through Tactical Anatomy.

20 Q. Do you keep records of these trainings?

21 A. Yes, I do.

22 Q. How far back do you keep these records?

23 A. Back to 2006, I would imagine.

24 Q. And do you have any academic publications in the  
25 past ten years?

1 A. No.

2 Q. Have you ever published a medical literature?

3 A. Yes.

4 Q. How many times?

5 A. Five to ten times. And this was all back when I  
6 was still associated with the research organization at  
7 Calvary, so my last publication would have been 1990,  
8 1991, something like that.

9 Q. Is this before you received your MD degree?

10 A. Yes, I haven't published anything since I got my  
11 MD.

12 Q. Have you published anything related to trauma?

13 A. Medical trauma, no.

14 Q. Are you a ballistics expert, Dr. Williams?

15 A. I am not a ballistics expert, but I have a high  
16 degree of familiarity in the field, and I know a lot of  
17 ballistics experts, yes.

18 Q. I'm sorry. Say that last portion. I just didn't  
19 catch it.

20 A. I know a lot of ballistics ex -- people that I  
21 would consider ballistics experts that I refer to  
22 expertise. Most laymen would consider me ballistics  
23 expert, but I -- I tend to defer to my colleagues that are  
24 more advanced in the field than I am.

25 Q. What is the name of a layman who would consider

1       you a ballistics expert?

2       A.       Rob Mitchell. Anybody who doesn't study  
3       ballistics would have to consider my knowledge to be  
4       expert above their own.

5       Q.       So is it your testimony I would consider you a  
6       ballistics expert?

7       A.       I'm being facetious, Mr. Mitchell, of course. But  
8       anyone who has not studied ballistics to any great extent  
9       would consider my knowledge expert. So, for example, when  
10      I went -- I attended a revolver symposium in -- at a gun  
11      site in Arizona in late November. Even though I was not  
12      there as an expert, I was deferred to as an expert by many  
13      of the instructors present because of the fact that I have  
14      known expertise in the firearms community in this area.

15             So I don't mean to dissimulate. Truly, I don't.  
16      But I've never considered myself to be a ballistics  
17      expert. I'm more of an expert in the terminal effects of  
18      ballistic projectiles, and the distinction is very real.

19      Q.       So you don't consider yourself a ballistics  
20      expert?

21      A.       That would be correct.

22      Q.       Have you ever published in ballistics literature?

23      A.       I have not.

24      Q.       I'm sorry, what was that?

25      A.       I have not.



1 Q. Now, returning to your expert report, on page 14,  
2 did you conclude that firing squad is a feasible means of  
3 execution in Tennessee?

4 A. I did.

5 Q. What does it mean for a firing squad to be  
6 feasible?

7 A. Well, my -- my definition of feasibility would be  
8 that it would be feasible to take a condemned person to a  
9 place of execution, by personnel of the State of Tennessee  
10 Department of Corrections, to affix that person in such a  
11 manner that he could not avoid the projectiles, to  
12 assemble a group of riflemen, employed by or engaged by  
13 State of Tennessee Department of Corrections, and that  
14 they should be able to shoot him to death with those  
15 rifles in an expedient manner that would result in a quick  
16 and relatively painless death.

17 Q. And that's what it means for an execution by  
18 firing squad to be feasible in Tennessee?

19 A. That's what I would say feasibility entails.

20 Q. And is this still your conclusion today that  
21 execution by firing squad is a feasible means of execution  
22 in Tennessee?

23 A. Yes.

24 Q. Has your conclusion changed in any way from  
25 November 10, 2021?

1 A. It has not.

2 Q. Did you also conclude that firing squad execution  
3 will result in a quick and painless death?

4 A. Yes.

5 Q. What does it mean to have a painless death?

6 A. Well, it's highly subjective, sir. Pain is a  
7 highly subjective function. But in the -- in the grand  
8 scheme of things, a death that involves absolutely no  
9 sensation, no neural sensations of a noxious nature.  
10 There are -- such a thing is extremely rare. It is  
11 achievable, but it's extremely rare.

12 Q. Painless death is extremely rare?

13 A. If we're talking about neurological definition of  
14 zero pain, yeah, it's extremely rare. Death is -- death  
15 is almost always -- and when I say almost always, I mean  
16 in the -- the quantities of deaths that may be truly  
17 painless, are infinitesimal, a drop in an ocean. Pain is  
18 always involved in death.

19 So when I speak of painless, I'm speaking in terms  
20 of the overall spectrum of pain that a person goes through  
21 in the process of passing from life to death. Death by  
22 gunshot wound, by firing squad, is as about as painless as  
23 it gets, short of a gunshot wound directly to the brain  
24 stem, which is the only thing I can say -- I can think of  
25 that will actually result in an instantaneous death with

1 no more neurological impulses conveying pain to the brain.  
2 That's the only exception.

3 Q. Could the same gunshot in two different  
4 individuals create different experiences of pain for each  
5 of those individuals?

6 A. It could do. I mean, there's -- there's -- it's  
7 hard to compare apples to apples because human -- just  
8 variations in human anatomy are so wonderful and varied  
9 that what appears to be exactly the same sort of gunshot  
10 wound in one person may actually result in a very  
11 different, subjective impression in another person.

12 Blood vessels don't follow an anatomically  
13 prescribed pattern. Neither do nerves. So it's very  
14 possible that a wound that would be relatively painless in  
15 one man might be considerably more painful in another.  
16 But in the main -- if we look at an average, if you will,  
17 of similar injuries, whether it's gunshot wounds, crush  
18 injuries, electrical injuries, what have you, they'll all  
19 produce a -- they will all tend to exhibit central  
20 tendencies in the Gaussian format, just like anything  
21 else.

22 Q. As an emergency department physician, have you  
23 ever seen a painful death?

24 A. Many times.

25 Q. How many times?

1 A. Many times.

2 Q. Under what circumstances?

3 A. Death by heart failure, death by myocardial  
4 infarction, people who've died from traumatic injuries in  
5 motor vehicle collisions, deaths from infectious disease  
6 resulting in cardio respiratory failure. The list goes  
7 on.

8 Q. What are some other examples in that list?

9 A. Death by drug toxicity, death by edged weapons,  
10 death by blunt instruments, beating to death, death by  
11 gunshot wound, of course, death by electrical injury,  
12 death by burns.

13 Q. And those are all examples of painful death you've  
14 seen as an emergency department physician?

15 A. Yes.

16 Q. You mentioned death by gunshot wounds. How many  
17 painful deaths by gunshot wounds have you seen?

18 A. Not too many. Not too many.

19 Q. Out of the hundreds and hundreds of gunshot wounds  
20 you've treated?

21 A. As I said -- as I told you, most of the people  
22 that I see who have gunshot wounds don't die in the  
23 emergency room. They may die in the operating room, they  
24 may die in the hospital later, or they may be dead by the  
25 time I see them. So the number -- number of actual deaths

1 that I see, as they happen, is relatively small; a few  
2 dozen.

3 Q. Dr. Williams, what does it mean to have a quick  
4 death?

5 A. It's very subjective, isn't it? You talk to the  
6 man who's taken six months to die from very painful bone  
7 metastasis from his prostate cancer and ask him what a  
8 quick death is. He'll tell you something very differently  
9 than the man who dies from 24 hours of slowly suffocating  
10 in his pulmonary fluids that are accumulating because of  
11 congestive heart failure.

12 The man who's dying from metastasis will consider  
13 that a slow death by suffocation, over 24 hours, to be a  
14 quick and preferable way to die. It's -- it's a  
15 meaningless question, sir. The quickness is entirely  
16 subjective.

17 Q. So when you concluded that firing squad will  
18 result in a quick death, that was entirely a subjective  
19 use of quick?

20 A. It's a subjective term that I think most people  
21 can identify with. Since you and I have not had to face  
22 death personally, we can only draw our -- our frame of  
23 reference from what we've read and heard. So we look at  
24 what people have gone through, in the course of their  
25 dying, as it's reported to us or as we observe ourselves,

1 and then we have to make conclusions as to what we think  
2 would be quick or by comparison.

3 Now, from myself, looking at -- having seen people  
4 die by inches over months or even years, I would consider  
5 a death that takes five or six or ten seconds from a  
6 gunshot wound -- or a series of gunshot wounds to the  
7 chest to be very quick indeed, but that's my subjective  
8 opinion. You know, the concept is not one that has ever  
9 been quantified in any literature.

10 Q. Do you consider a quick death to be a death that  
11 occurs in under 30 minutes?

12 A. Compared to dying by inches from bone metastasis,  
13 yeah. I mean, this is -- it's all relative, sir. You  
14 can't --

15 Q. Have you ever -- have you ever personally  
16 witnessed someone die by a quick death?

17 A. I've seen people die very quickly, yes.

18 Q. How many times?

19 A. Dozens.

20 Q. Under what circumstances?

21 A. By cardio -- the list I gave you earlier:  
22 Myocardia infarction -- well, not the whole list -- motor  
23 vehicle collisions and injuries sustained from those.  
24 Those -- basically, traumatic deaths can be very quick  
25 indeed. Most medical deaths take a bit longer. The sole

1 exception to that, that I can think of, would be -- that's  
2 actually not the sole exception. The two major exceptions  
3 would be myocardia infarction with association cardiac  
4 arrhythmias, and the other one would be, of course,  
5 massive stroke, which would be very quick.

6 Q. Have you ever been present on the scene of a motor  
7 vehicle accident when someone died?

8 A. Yes.

9 Q. How many times?

10 A. Half a dozen. No, not that many. Twice. Twice  
11 that I've actually seen the person die.

12 Q. And were you present when that motor vehicle --  
13 when those two motor vehicle accidents happened?

14 A. Unfortunately, yes.

15 Q. Were you present in your capacity as a physician?

16 A. I was there as a bystander in both cases, but I  
17 did render medical aid in one case.

18 Sorry. Dogs.

19 Q. Is it still your conclusion today that execution  
20 by firing squad will result in a quick and painless death?

21 A. That is my contention, yes.

22 Q. Has your conclusion changed in any way from  
23 November 10, 2021?

24 A. It has not.

25 Q. What is your basis for concluding that execution

1 by firing squad is a feasible means of execution in  
2 Tennessee?

3 A. By the means that I described to you earlier.  
4 It's not difficult to take a condemned person to a place  
5 where he can be shot to death. It's not difficult for the  
6 department of corrections to assemble the rifles,  
7 ammunition, and riflemen necessary to commit an execution.

8 The complexities, the mechanics, the -- the steps  
9 that need to be taken for that sort of execution are no  
10 more onerous than those required for execution by lethal  
11 injection. And in some cases, it may be considerably less  
12 fuss and bother. It's certainly less than the fuss and  
13 bother involved with death by electrocution.

14 Q. Have you ever attended a death by electrocution?

15 A. I've seen death after electrocution, yes. I have  
16 not attended an execution by electrocution.

17 Q. What do you mean by you've seen death after  
18 electrocution?

19 A. I've attended -- I've attended to individuals  
20 who've been electrocuted in -- in an accidental situation  
21 where they have been brought to me shortly thereafter. In  
22 each case, they were already dead. They had already died.  
23 They died at the scene.

24 Q. So you have not seen a lethal injection execution  
25 occur?



1 A. I have never seen an execution, of any kind, in  
2 person.

3 Q. Have you ever witnessed an execution of any kind  
4 be rehearsed?

5 A. No.

6 Q. What type of firearm would the defendants need in  
7 this case to execute someone by firing squad?

8 A. Rifles. Center-fired rifles, major caliber. What  
9 we would -- is commonly referred to as a high-powered  
10 rifle; a hunting rifle, a deer rifle, a police rifle.  
11 Something with a caliber -- well, a caliber is -- is just  
12 a measure of the diameter of the bullet or the diameter of  
13 the bore of the barrel.

14 Really, what we're talking about is a -- is a  
15 firearm capable of firing a projectile with sufficient  
16 energy to kill a large mammal, so a deer-hunting rifle is  
17 what most people would identify.

18 Q. Are any of the examples you mentioned preferable  
19 to any of the others?

20 A. Not really. Not really. Any -- any hunting rifle  
21 that is in common use -- I should say hunting ammunition  
22 that is in common use -- any rifle ammunition that is in  
23 common use for law enforcement purposes should be  
24 sufficient for this task.

25 Q. When an execution by firing squad occurs, should

1 the condemned be fixed in a stationary position so the  
2 condemned does not become a moving target for the  
3 riflemen?

4 A. Absolutely.

5 Q. Should a target be placed on the condemned?

6 A. I think that would be expedient, yes.

7 Q. Where should the target be placed?

8 A. It should be placed over the upper portions of the  
9 cardiovascular bundle. So I would -- I would estimate --  
10 I mean, something -- a paper or cloth target or a  
11 piece -- whatever -- a flat piece of something that's  
12 about 3 to 4 inches in diameter and placed over the lower  
13 part of the sternum, overlapping the left sternum border,  
14 and that would be an anterior posterior presentation. The  
15 final would be upper part of the ventricles, the atria,  
16 and the other roots, the pulmonary trunk roots and so  
17 forth.

18 Q. Should the target be placed on the head?

19 A. If you're just -- if your protocol requires that  
20 the person be shot in the head, then put it on the head.  
21 That's up to the state doing the executing, sir. It's not  
22 up to me.

23 Q. Is one purpose for placing the target on the chest  
24 to avoid disfiguring the face out of sympathy and dignity?

25 A. I believe that is the case. I've seen it. I've

1 read it mentioned in several sources, yes.

2 Q. And is another purpose for placing the target on  
3 the chest to enable postmortem identification?

4 A. I've read that as well, yes.

5 Q. Do you agree with what you've read?

6 A. It makes some sense. I have no opinion one way or  
7 the other.

8 Q. You use the term "cardiovascular bundle." Is that  
9 a medical term?

10 A. Yes.

11 Q. What is the cardiovascular bundle?

12 A. It is the collection of the heart and the great  
13 vessels in the mediastinum of the chest. They  
14 are -- these structures are all closely together. They  
15 comprise the -- in vertical presentation. The  
16 cardiovascular bundle is roughly from the bottom of the  
17 sternum up to about two-thirds of the way up the sternum.  
18 And about -- you know, the -- on the left extreme would be  
19 the apex of the heart; the right extreme would be the  
20 right atrial border; vertically, the top of the aortic  
21 arch; and in the inferior margin would be roughly the apex  
22 of the heart as well.

23 Q. Are there any other structures in the  
24 cardiovascular bundle?

25 A. Within the cardiovascular bundle, there are the

1 heart, which comprises the two atria and two ventricles.  
2 There'd also be the aortic root, the pulmonary trunk, the  
3 two pulmonary arteries. You also have the return  
4 vascular, which would comprise the -- the venous sinus,  
5 the superior vena cava -- or the inferior vena cava, and  
6 the pulmonary veins returning from the -- the lungs. So  
7 these -- these are the primary components of the  
8 cardiovascular bundle.

9 Q. Do you agree that if someone is shot in 80 percent  
10 of the chest, that it will not produce anything close to  
11 cardiovascular incapacitation?

12 A. Yes, that's quite true.

13 Q. Is cardiovascular incapacitation desirable for  
14 firing squad execution?

15 A. That is the primary mechanism by which mortality  
16 is achieved, yes.

17 Q. What is cardiovascular incapacitation?

18 A. The mechanism of death, of dying, is to cause the  
19 brain to cease to function. The central nervous system,  
20 the brain, is where the life force appears to be  
21 concentrated, and once the brain ceases to function,  
22 that's considered brain death, and that is the currently  
23 accepted, final definition of death in the medical  
24 literature and consensus among physicians is brain death.

25 Brain death can be achieved by destruction of the

1 brain itself, but it's more commonly achieved or  
2 accomplished or results if some -- often -- usually, it's  
3 not intentional, but it's -- it -- it's the culmination of  
4 the lack of circulation of blood to the brain with the  
5 delivery of oxygen to the brain.

6 Oxygen is absolutely necessary for the brain to  
7 function, and the brain tissues, the neurons in the brain,  
8 require a constant supply of oxygen to stay alive. Brain  
9 cells cease to function after they have lost sufficient  
10 oxygen to keep their energy cycles working, and this takes  
11 only a matter of a few seconds, once circulation has  
12 ceased to the brain.

13 So if you stop circulation at the cardiovascular  
14 bundle, you stop delivery of oxygen to the brain, and the  
15 brain's reserves of oxygen that it can maintain function  
16 with is typically exhausted within six, seven, maybe ten  
17 seconds. In an individual who has hyperventilated prior  
18 to the moment of death, that brain reserve may be a little  
19 longer. May go up to 15, 16, 20 seconds by some  
20 estimates, but it certainly doesn't last longer than that.

21 So when we use the cardiovascular gunshot wound as  
22 our means of execution, what we're really doing is  
23 stopping the brain oxygen delivery system, and  
24 that's -- that's how you accomplish inflicting mortality  
25 upon the individual.

1 Can we pause now, sir? I could use a break.

2 Q. Absolutely. Should we say 13 minutes, 10:45  
3 central?

4 A. That's fine. I don't need that long. But if that  
5 works for everybody else, I'm fine with it.

6 Q. Just to round it up to something easy.

7 A. Sure, let's do that.

8 Q. Thank you.

9 A. Thank you, sir.

10 (WHEREUPON, a recess was taken at 10:33 a.m. and  
11 the deposition resumed at 10:45 a.m.)

12 BY MR. MITCHELL:

13 Q. Dr. Williams, during our break, did you look at  
14 anything?

15 A. Just checked some e-mails, that's all. Not  
16 relevant to this case.

17 Q. Okay.

18 A. Nothing relevant.

19 Q. Related to the firing squad?

20 A. No, just business stuff.

21 Q. Related to any other case?

22 A. No, sir.

23 Q. Did you speak with anyone during our break?

24 A. I did not. I spoke to my wife. She was on her  
25 way out the door.

1 Q. About this deposition?

2 A. No, uh-huh. No.

3 Q. Is it your position that it's feasible for the  
4 defendants in this case to execute by firing squad?

5 A. I'm sorry. Can you repeat the question.

6 Q. Sure.

7 Is your position that it is feasible for the  
8 defendants in this case to execute an inmate by firing  
9 squad?

10 A. Oh, okay. I'm sorry. I'm mixing up plaintiffs  
11 and defendants in my head. Yes, sir, I believe that's  
12 true.

13 Q. It is feasible for the defendants to execute an  
14 inmate by firing squad?

15 A. I have no familiarity with the Department of  
16 Corrections, so I really don't know where they would do  
17 it. It's up to them.

18 Q. Is there a risk that a bullet could ricochet  
19 during a firing squad execution?

20 A. If they exercise the level of care and intention  
21 as done by other jurisdictions, that risk is virtually  
22 nil, but there is a slight possibility.

23 Q. What is the level of care and intention exercised  
24 by other jurisdictions?

25 A. Well, just to use the Utah firing squad death

1 chamber, for example, they provide for a very good level  
2 of protection for witnesses and the execution squad itself  
3 by placing the other individuals behind bullet resistant,  
4 ballistically impervious materials. So they have  
5 ballistically resistant windows for the witness viewing  
6 chambers, which are embedded in ballistically resistant  
7 walls. I'm not exactly sure what the construction is, but  
8 even a direct -- a directive fired caliber from one of the  
9 execution rifles couldn't penetrate them at a 90-degree  
10 angle of incidence. That's what I'm told.

11 Likewise, the execution squad is behind a  
12 ballistically impervious barricade, which has various  
13 small firing slits located in them, so there's a remote  
14 possibility that a ricochet could come back through one of  
15 those slots and injure one of the execution squad members,  
16 but, again, the likelihood of that is extremely small.

17 So that's the nature of the execution chamber, as  
18 I understand it. And this is from testimony that I've had  
19 deposition at trial and that I have reviewed in other  
20 cases. I have not actually seen the execution chamber.

21 Now, the other -- I think the more important means  
22 of preventing collateral damage, unintended injuries from  
23 ricochet, is that the -- the subject, the condemned  
24 person, is strapped into a chair, which is affixed to a  
25 firm platform, and the backstop for the chair consists of



1 heavy lumbar, behind which is some absorbant material that  
2 slows the bullet down. And then behind that is a heavy,  
3 ballistically impervious blanket, for lack of a better  
4 term, which bullets are unlikely to penetrate or bounce  
5 off of.

6 And then should any of these bullets pass through  
7 the body of the condemned through the plywood -- or not  
8 plywood -- but the lumbar or through the ballistically  
9 absorptive materials behind that, it essentially sandbags  
10 it. Then the -- the Kevlar blanket will absorb the  
11 remaining injury of those -- energy of those bullets and  
12 they will not pass any further.

13 Since there's no hard surfaces of sufficient  
14 hardness that a bullet would bounce used in the  
15 manufacturer of the chair, even if a bullet was to go  
16 astray by a substantial margin, which is extremely  
17 unlikely given the training that they use for the  
18 execution team -- I'm not saying impossible, but extremely  
19 unlikely -- the -- the possibility of a ricochet is  
20 virtually nil. You never say 100 percent certainty, but  
21 very, very low probability that anything would ever bounce  
22 off.

23 Q. Is everything that you just testified to in the  
24 Utah protocol?

25 A. Yes, sir.

1 Q. And those are all measures Utah takes to prevent a  
2 ricochet from occurring, correct?

3 A. That's my understanding, yes.

4 Q. What is the chair that the condemned is affixed to  
5 in Utah made of?

6 A. Lumbar, wood.

7 Q. Now, what other measures does Utah take to address  
8 the possibility of a bullet ricochetting?

9 A. Pretty much it. I don't think -- I can't think of  
10 anything else. I may have omitted something  
11 unintentionally, but I think that covers it all.

12 Q. Are there any other measures you can think of that  
13 would address the possibility of a bullet ricochetting  
14 during an execution by firing squad?

15 A. I can't think of anything over and above the  
16 measures I've given you that has any -- there's any need  
17 for, or any feasibility of constructing.

18 Q. What sort of experience -- I'm sorry, what was  
19 that last part?

20 A. You know, if I thought about it, I might be able  
21 to come up with a couple other ideas. Maybe you could  
22 extend the Kevlar blanket to the sides of the -- of  
23 the -- of the chair on the platform so that you'd have  
24 more of a -- three sides surround the individual, you  
25 know, and over the top of it. I suppose that would work

1 or could work. But then that would block the view of the  
2 condemned person from the witnesses, so that really  
3 wouldn't be feasible, unless you put the witnesses  
4 behind -- on the same side as the execution team, and then  
5 that would involve building a second level.

6 I don't know. I mean, there's -- there's things  
7 that could be done. But the steps that have been taken by  
8 Utah Department of Corrections seem to have been well  
9 thought out, very thorough, and there certainly has never  
10 been a reported incident of ricochet in Utah, in any of  
11 the executions that they've undertaken by firing squad  
12 since the mid-1800s, so. And I am frankly not aware of  
13 any reports of anyone injured by a ricochet during a  
14 firing squad -- a firing squad execution ever. So I don't  
15 know that anything beyond what Utah has done is -- is  
16 necessary.

17 Q. How many executions by firing squad has Utah  
18 conducted since the mid-1800s?

19 A. I don't have that number at my fingertips. It's  
20 about 40, I believe. No, that's too many.

21 Q. What sort --

22 A. Yeah. Oh, I just looked at this last month -- or  
23 in November. In the mid-20s, I think, 25 or so.

24 Q. What sort of experience is necessary to execute  
25 someone by firing squad?

1 A. You mean aside from administrative experience.

2 Q. Well, firearms proficiency?

3 A. Oh, certainly, yeah. In terms of the  
4 executioners, the riflemen, yeah, they would need to be  
5 experienced. They need to be able to exhibit --  
6 certainly, they would need to meet the minimum standard  
7 for law enforcement training in their state. Rifle  
8 qualification courses of firearms are very well  
9 established in every state. Of course, there are firearm  
10 or marksmanship requirements that must be met. These vary  
11 from state to state.

12 It's been awhile since I've looked at Tennessee's  
13 requirements, but the peace officers in Tennessee must  
14 qualify -- if they're authorized to use a rifle, they must  
15 qualify with it on a regular basis; I believe twice  
16 annually. They must be able to hit at a specific target  
17 in a specific range, which is, you know, within a  
18 reasonable degree of certainty and acceptable standard for  
19 police firearms proficiency. And, in fact, the standard  
20 that they must meet in -- in the rifle qualification is a  
21 higher standard than would be required to hit a 3-inch  
22 circle or 4-inch circle, on the chest of a condemned  
23 person, at a distance of 21 feet.

24 So the proficiency of any certified rifle --  
25 certified peace officer who is certified to use a rifle on

1 duty, any of those individuals would have the requisite  
2 marksmanship capabilities to serve on a firing squad.

3 Q. Do you agree that any firing squad shooter should  
4 be trained in marksmanship?

5 A. Yes.

6 Q. Do you agree that any firing squad shooter should  
7 be certified in marksmanship?

8 A. Yes.

9 Q. How long does it take to be trained in  
10 marksmanship?

11 A. It depends on the state's requirements. Most  
12 states have a requirement -- a minimum requirement for  
13 marksmanship training with firearms that they have in  
14 their prescribed academy curriculum.

15 Q. Do you know whether Tennessee has a requirement?

16 A. I haven't looked at the training requirement  
17 recently, but yes, I believe they do have it. I do know  
18 that the agencies in Tennessee that I have trained with  
19 have rigorous standards, and I believe those are -- I know  
20 those follow the guidelines from Tennessee POST  
21 requirements. But I think in Nashville -- Nashville Metro  
22 actually goes over and above those. So those are agencies  
23 that meet and exceed the State requirements within the  
24 state of Tennessee.

25 Q. What agencies have you trained with in the state

1 of Tennessee?

2 A. I've conducted training at Metro Nashville PD on  
3 three occasions, I believe, in the past. And those  
4 trainings have been attended by multiple agencies, not  
5 just Metro Nashville PD, but Tennessee State Patrol have  
6 attended, members of that organization, and a number of  
7 the local police force and -- and sheriff's department  
8 personnel in that part of Tennessee.

9 Q. When was the most recent training in Tennessee you  
10 conducted?

11 A. I'd have to look at my records. I believe it was  
12 2008. Might have been 2009.

13 Q. Is there a difference between shooting a human and  
14 shooting a target?

15 A. In terms of the mechanics, no. In terms of the  
16 subjective experience, there's an enormous difference.

17 Q. What is that difference in terms of the  
18 psychology?

19 A. The difference is enormous. Lieutenant --  
20 Lieutenant Colonel Dave Grossman wrote a book, "On  
21 Killing," which I have supplied the publication  
22 information on. If you haven't read it, I highly  
23 recommend it. It's -- Lieutenant Colonel Grossman is a --  
24 is an expert on the psychology of killing, possibly the  
25 leading world expert on it.

1           He comments on his -- in the introduction to his  
2 book, that the act of homicide is universal human phobia.  
3 We are instinctly -- as human beings, instinctively have a  
4 psychological barrier. It's hardwired into us at some  
5 level, and we have a barricade that makes killing another  
6 human being a frightening, if not a phobic, stimulus in  
7 such that it must be conditioned out of the individual by  
8 training in order to act in a manner that one can actually  
9 inflict death upon another human being.

10           History's full of the examples of people who have  
11 successfully trained in this endeavor. And it doesn't  
12 matter whether it's on the criminal side or on the side of  
13 law and order, individuals must be trained to inflict harm  
14 on another person.

15 Q.       How long --

16 A.       That --

17 Q.       -- does it take to train -- how long does it take  
18 to train to inflict harm on another person?

19 A.       It varies. It varies with the person. And since  
20 I don't conduct that training, I couldn't give you a  
21 specific time frame. David Grossman suggests that it can  
22 be done in as little as less than six months by taking a  
23 raw recruit into the United States military and turning  
24 that individual into an effective killer of human beings.

25 Q.       Do you agree that the vast majority of people find

1 it psychologically much more difficult to shoot a person  
2 than a target?

3 A. Absolutely, I agree.

4 Q. Have you spoken with anyone at the Tennessee  
5 Department of Corrections about executions by firing  
6 squad?

7 A. I have not.

8 Q. Do you know, personally, any individuals from  
9 Tennessee who are willing to carry out execution by firing  
10 squad?

11 A. I haven't asked them specifically, but I know a  
12 number of people who I think might be willing to do so.

13 Q. But you don't know because you haven't asked them  
14 if they're willing?

15 A. I haven't specifically asked them.

16 Q. So is the answer no, you do not know any  
17 individuals in Tennessee who are willing to carry out an  
18 execution by firing squad?

19 A. True, that's my answer.

20 Q. About how many sworn officers are there in the  
21 state of Tennessee?

22 A. When I looked at that a few weeks ago, I believe  
23 it was about 15,000.

24 Q. And what is the basis for that statistic?

25 A. I looked it up on the State of Tennessee website.



1 Q. Where on the State of Tennessee website did you  
2 look that up?

3 A. Couldn't tell you. I just did a search on the  
4 Tennessee website. Yeah, I couldn't tell you exactly  
5 where it is.

6 Q. What State of Tennessee website was that?

7 A. Tennessee.gov.

8 Q. Has it been your experience that all law  
9 enforcement personnel are expertly familiar with the use  
10 of a rifle?

11 A. No.

12 Q. Do you agree that a death by firing squad is not  
13 guaranteed to be free from human error?

14 A. Do I guarantee -- can you put that without the  
15 double negatives.

16 Q. Do you agree that a death by firing squad could  
17 have human error?

18 A. Yes, I agree.

19 Q. Now, in your expert report, you cited both Utah's  
20 current protocol for execution by firing squad and older  
21 firing squad protocol of the U.S. Army in support of your  
22 conclusion that execution by firing squad is a feasible  
23 means of execution; is that right?

24 A. No, the current U.S. military method is -- is  
25 feasible, their old protocol is feasible, and the current

1 Utah protocol are feasible. They're all feasible. I  
2 alluded to both a former and a current U.S. military  
3 protocol, I believe. In fact, in any case, if I didn't  
4 refer to it in that way, I'm sorry. But I have testified  
5 as to all three of those protocols. I may be confusing my  
6 -- my case here.

7 Q. So here, on page 4 of your report, under Materials  
8 Considered, you considered, first, Utah's Protocol for  
9 Execution by Firing Squad, correct?

10 A. Correct.

11 Q. And it says that that was attached to this report?

12 A. I believe it was, yes.

13 Q. And if we scroll down, do we see that attachment  
14 anywhere before your CV?

15 A. I don't see it there, no.

16 Q. Do we see it after your CV?

17 A. I guess not, no.

18 Q. And two, do you also consider the U.S. Army's  
19 protocol for executions by firing squad attached to this  
20 report as Appendix C?

21 A. Yes, I did consider the U.S. Army's protocol.

22 Q. And did we see that anywhere attached to this  
23 report before or after your CV?

24 A. I don't see it here, no, sir.

25 Q. And is your position that there are two U.S. Army

1 protocols that you considered in preparing this report?

2 A. Yes, there are.

3 Q. And what are the dates of those U.S. Army --

4 A. The former protocol -- the former protocol was, I  
5 believe -- and I'd have to look at the stuff again -- it  
6 was about 1947 and '48, and it was active until 1957 or  
7 '58. The current protocol was developed and published in  
8 1957 or '58. Now, that's the best of my recollection. I  
9 might be a little bit arrear.

10 Q. So do you see on page 11 you wrote: To prepare  
11 for this report, I reviewed Utah's current protocol for  
12 execution by firing squad and an older firing squad  
13 protocol of the U.S. Army?

14 A. Yes.

15 Q. And you only mentioned one U.S. Army protocol; is  
16 that correct?

17 A. Yes.

18 Q. But it's your testimony that you considered two  
19 U.S. Army protocols?

20 A. Yes. I use the term an "older" to refer to the  
21 fact that it preceded the Utah protocol. And I was  
22 referring to -- it doesn't state this clearly enough.  
23 That's an error in my grammar. I was -- I reviewed and  
24 considered both of these as currently active protocols, so  
25 the Utah protocol and the older, current firing squad

1 protocol of the U.S. Army are the two that are my primary  
2 sources here. I did review the earlier U.S. Army protocol  
3 as background or context material for the current U.S.  
4 Army protocol.

5 Q. Did you provide that earlier, previous U.S. Army  
6 protocol to your attorneys to supply as materials  
7 considered in this report?

8 A. I don't recall if I did or if I didn't.

9 Q. And here, you see at the bottom of page 11, where  
10 it says: The Army's procedure differs in some minor, but  
11 practical points?

12 A. Yes.

13 Q. Are all of these points of procedure from the  
14 1950s protocol?

15 A. Yes, sir.

16 Q. What in your report relied on the 1940s Army  
17 protocol?

18 A. We'd be going back to the first case, maybe the  
19 second case that I had testified on, or provided a report  
20 on, which would have been the -- the case in -- the  
21 Ledford case in Georgia in 2017 and the Danny Bible case  
22 in Texas in 2017. For those reports, I only had the  
23 earlier U.S. military protocol. I didn't have the current  
24 one. I'm not sure exactly how that came about, but  
25 we -- I prepared those reports, at that time, relying on

1 the earlier U.S. Army protocol.

2 Q. And is execution by firing squad still an  
3 authorized means of execution by the U.S. Army?

4 A. Yes.

5 Q. How do you know that?

6 A. I asked a fellow who works for the -- had worked  
7 for the Judge Advocate General some years ago.

8 Q. Did you ask him some years ago or he worked --

9 A. Yeah, I asked him -- I asked him back in 2017.  
10 Actually, yeah, he had been, and he said as far as he was  
11 aware, it was still an active means of execution at that  
12 time.

13 Q. And did you know if it's still an active means of  
14 execution on January 4, 2022?

15 A. I know within a reasonable degree of certainty. I  
16 certainly haven't come across anything that says they've  
17 stopped using it, so let's put it that way.

18 Q. And what was the name of this gentleman you spoke  
19 with in 2017?

20 A. His name would be John Holschen, I believe. It  
21 might have been John Holschen. It may have been Gary  
22 Roberts. I don't recall which one exactly. They both  
23 have expert knowledge.

24 Q. Did you speak with them in person or through some  
25 sort of media?

1 A. On the telephone.

2 Q. And what was Mr. Roberts' role with the U.S.  
3 Government?

4 A. Dr. Roberts, not Mr. Roberts -- Dr. Roberts  
5 is -- or was at the time in the United States Navy  
6 Reserve, held a commission in that organization, and he  
7 had -- Dr. Roberts is probably the most -- foremost world  
8 expert in ballistics -- firearms ballistics in the world,  
9 studied under Dr. Fackler, and he has testified before  
10 Congress, before inquiries at the Pentagon, and to the  
11 Judge Advocate General by his communication to me. So  
12 that would be his role. He has been in an advisory  
13 capacity to the -- to the military and to the government  
14 in general.

15 Q. And what was the other gentlemen you mentioned?  
16 Was it Holsbine?

17 A. Holschen. John Holschen, H-O-L-S-C-H-E-N, I  
18 believe is the spelling. I know Mr. Holschen from the  
19 ballistics -- Internet wound ballistic community and from  
20 personal communication. He currently conducts training,  
21 part-time training. Actually, he does have a training  
22 coming. That might be his primary means of earning an  
23 income now in -- as a trauma medic. And he served in the  
24 United States Armed Forces as a field medic in Afghanistan  
25 and Iraq for a number of years.

1 Q. Is the U.S. Army's protocol for execution by  
2 firing squad more practical than Utah's protocol?

3 A. I don't think either one is more or less practical  
4 than the other. The Utah protocol is a bit more specific  
5 in some points, less specific in others. The differences  
6 in practicality are not in the protocols themselves but in  
7 the way the protocol's interpreted and acted upon. The  
8 administrative processes that they've developed in Utah  
9 for firing squad executions are over and above the  
10 verbatim reading of their protocol, but I think they've  
11 done a good job with it.

12 I do not know when the United States military last  
13 executed someone by firing squad with any real certainty.  
14 And so I -- and I have been unable to speak with anyone or  
15 see testimony or written documents that suggest what their  
16 interpretations of their protocol is, so.

17 Q. Do you know -- do you know whether the U.S.  
18 military executed someone by firing squad in the last  
19 50 years?

20 A. I don't know. I don't know of any executions done  
21 by the United States military after 1947.

22 Q. And going back to the two individuals we discussed  
23 a second ago, do you have any other basis, other than your  
24 conversations with those individuals, for concluding that  
25 execution by firing squad is still an active, authorized

1 means of execution by the U.S. military?

2 A. No, I think I -- I think I've done some -- I know  
3 I've done some literature searches on the Internet to see  
4 if I could find any information to suggest that this is no  
5 longer on the books and I wasn't able to find anything  
6 suggesting that the protocol has ever been withdrawn or  
7 that it is not being used.

8 So I have found no evidence that they've withdrawn  
9 the protocol, which suggests to me that they likely still  
10 have it on their -- in their files and on their books.  
11 But that's just a conclusion I've drawn. That's not a  
12 statement of fact. That's just my opinion of it.

13 Q. How many riflemen does Utah's protocol require?

14 A. It requires four, with an alternate.

15 Q. Are there any backups?

16 A. Backup riflemen? That's the alternate.

17 Q. Yeah. And how many riflemen does the U.S. Army's  
18 protocol require?

19 A. Eight.

20 Q. Which number is more appropriate?

21 A. I don't think there's any material difference.

22 Q. You don't think four is any -- is materially  
23 difference than eight, double?

24 A. I do not.

25 Q. Why not?



1 A. Because ballistic energy imported by a single  
2 rifle bullet is more sufficient to cause death by this  
3 mechanism. When you take -- when you triple or quadruple  
4 that amount, it's just a matter of literal overkill.  
5 Extend that to eight riflemen and it's even more so.  
6 The -- the ballistic energy of those projectiles and the  
7 destructive capacity of them is more than sufficient to  
8 kill.

9 Q. Do you know, in the Army's protocol, how far is  
10 the firing squad from the condemned?

11 A. I believe it's 35 feet, but I'd have to re -- I'd  
12 have to look at that again and review.

13 Q. And how far is the squad from the condemned in  
14 Utah's protocol?

15 A. Twenty-one feet.

16 Q. Which of these two distances is preferable?

17 A. For the -- in terms of the marksmanship  
18 capabilities of the individuals involved, the difference  
19 between 21 feet and 35 feet is negligible.

20 Q. So neither one -- neither distance is preferable  
21 when conducting an execution by firing squad?

22 A. In my opinion, no. It might be different in the  
23 opinion of the people running those firing squads, but  
24 the -- the degree of accuracy that can be obtained at  
25 either of those distances is well within the limits that

1 we need to stay within for successfully killing the  
2 condemned person.

3 Q. Dr. Williams, what is your basis for concluding  
4 that execution by firing squad in Tennessee will result in  
5 a quick and painless death?

6 A. As I've already testified, rifles will produce  
7 enough of a ballistic injury to the cardiovascular bundle  
8 that the individual will -- the individual so executed  
9 will cease to have any functional cardiovascular function  
10 within milliseconds of the impact of the bullets, and  
11 brain death will follow within a matter of seconds.

12 Q. Does this opinion rely on any assumptions?

13 A. I don't know what you would define as an  
14 assumption, sir. I mean, does that rely on my  
15 understanding of medical physiology? If you meant  
16 physiology, yes. I mean, these -- these are facts, not  
17 assumptions.

18 Q. Well, does your opinion that execution by firing  
19 squad in Tennessee will result in quick and painless death  
20 rely on riflemen hitting the target, for instance?

21 A. So you're saying hitting the target is an  
22 assumption.

23 Q. Isn't it an assumption? Can riflemen miss?

24 A. They can miss. I don't know that I'd define it as  
25 an assumption.

1 Q. Could there be a faulty round of ammunition?

2 A. Extremely unlikely.

3 Q. Possible?

4 A. Within the realm of possibility, yes.

5 Q. Is your opinion that the only painless method of  
6 death is a direct gunshot wound to the brain stem of the  
7 brain?

8 A. Well, it doesn't necessarily have to be a gunshot  
9 wound. It could be a piece of rebar falling off a  
10 building and getting -- but it -- basically, a traumatic  
11 injury to the brain stem, causing complete cessation of  
12 function of the brain stem, is necessary. And if you're  
13 dealing with something that's traveling as fast as a  
14 bullet, it will get there before the nerve transmission  
15 from the skin can get to the brain. So, yeah, that would  
16 be the only -- the only way that you can instantaneously  
17 incapacitate somebody.

18 Q. So would you agree that the only method of  
19 execution that would be completely painless is a direct  
20 gunshot wound to the brain stem of the brain?

21 A. That is my assertion, yes.

22 Q. Do you agree that the response by humans being  
23 shot in the chest with a rifle can be highly variable?

24 A. No, I would not say it's highly variable. The  
25 response is going to be pretty similar with -- from one

1 person to the next. Three rifle -- three rifle wounds,  
2 high-power rifle wounds, to the cardiovascular bundle are  
3 going to produce exactly the same effect within a very  
4 small variability.

5 Q. Dr. Williams, is this your expert report?

6 A. Yes.

7 Q. Do you see this sentence in the middle of the page  
8 where you state that you have interviewed personnel, who  
9 have served as field medics in the U.S. Armed Forces, with  
10 respect to the effects of a gunshot wound to the  
11 cardiovascular bundle?

12 A. Yes.

13 Q. In the following sentence where it says that those  
14 individuals have informed you that the response to being  
15 shot with a rifle in the chest will be highly variable?

16 A. Yes.

17 Q. Do you agree with what those individuals have told  
18 you?

19 A. I do.

20 Q. And is that consistent with your professional  
21 experience?

22 A. Yes, it is.

23 Q. How, in the response to being shot with a rifle in  
24 the chest be highly variable?

25 A. Well, if you look at those two sentences, you'll

1 see in the first one, I refer to being shot in the chest,  
2 and, second one, I refer to being shot in the  
3 cardiovascular bundle. These are two different  
4 structures, so we're not comparing apples to apples.  
5 Those are completely different statements.

6 A rifle shot to the chest can be highly variable  
7 because if you don't shoot the person in the  
8 cardiovascular bundle, response can be highly variable.  
9 If it just creases the skin, that could be called a chest  
10 wound. A bullet that penetrates the periphery of the  
11 chest, breaks a rib, and passes through the other side  
12 without reaching into the thoracic cavity, that's a  
13 different thing as well.

14 Something that hits you in the high chest, such as  
15 my own personal gunshot wound, without intervening --  
16 without penetrating into the thoracic cavity, would be an  
17 example of that. Yet again, that could be a gunshot  
18 wound. And, probably, the most common type of thoracic  
19 gunshot wound that I deal with is one that penetrates into  
20 the thoracic cavity on one side or the other, affecting  
21 part of the lung on one side or the other. And then there  
22 is a potential of a gunshot wound above the card -- the  
23 cardiovascular bundle in the central chest areas and the  
24 injuries that can occur there.

25 And, of course, there's the chest wounds to the

1 cardiovascular bundle. Notwithstanding, you have to  
2 consider the possibility of wounds that pass through the  
3 chest on a different angle that do not impact the  
4 cardiovascular bundle, but do impact the thoracic spine,  
5 which has a completely different set of symptoms, so --  
6 and presentation.

7 So there are multiple types of chest wounds that  
8 are included in that, and that's why it says highly  
9 variable and that's why I agree it is highly variable.  
10 The chest is a huge structure, a huge area of the body.  
11 It's not a very unique system. It's a large, anatomic  
12 quadrant where the cardiovascular bundle, which I refer to  
13 in this second segment -- section, second sentence in that  
14 paragraph, is a precisely defined, anatomic region of the  
15 body.

16 And the effects of that sort of gunshot wound are  
17 quite highly predictable, which is exactly what the  
18 medic -- the people that I've spoken to, in the third  
19 sentence of that paragraph, is exactly what they said.  
20 People struck in the cardiovascular bundle have a highly  
21 predictable response; they stop all purposeful movement  
22 almost immediately and they cease any signs of life or  
23 response in less than ten seconds.

24 Q. Dr. Williams, do you agree that a gunshot can be  
25 extremely painful?

1 A. The possibility exists that gunshot wounds can be  
2 very painful. Again, you have to put it into context: If  
3 you have a choice between a gunshot and a sword wound,  
4 even a knife wound -- knife wounds, edge weapon wounds  
5 tend to be much painful, in general, than gunshot wounds.  
6 Burns tend to be more painful than gunshot wounds.  
7 Traumatic fractures tend to be more painful than gunshot  
8 wounds. There's all kinds of degrees of pain.

9 But in terms of gunshot wounds, can they be  
10 painful? Yeah, they can be. They can be. Most of the  
11 ones that I see are not particularly painful compared to  
12 many other forms of trauma, as I've described.

13 Q. But you agree that they can be extremely painful?

14 A. Yes, sir, they can.

15 Q. Has anyone ever told you that a gunshot wound to  
16 the chest feels like being hit in the chest with a  
17 baseball bat?

18 A. Yep.

19 Q. How many people have told you that?

20 A. Dozens.

21 Q. Had all these people been shot in the chest?

22 A. Yeah. I'm talking about people who have been shot  
23 in the chest and are still conscious and talking to me.

24 Q. And dozens of them said it was equivalent to being  
25 hit in the chest with a baseball bat?

1 A. They might not have used the term "baseball bat"  
2 directly, but being hit in the chest with a blunt object,  
3 being punched in the chest, being hit by a rock in the  
4 chest, like being tackled at a football game, those  
5 are -- those are the kind of similes that people have put  
6 to me.

7 Q. How many individuals, who were shot in the chest,  
8 have told you that it felt like being hit in the chest  
9 with a baseball bat?

10 A. Specifically a baseball bat? I don't know. Maybe  
11 half a dozen, maybe less, maybe a little more, something  
12 along those lines.

13 Q. Does being hit in the chest with a baseball bat  
14 result in pain to the person who was hit?

15 A. You have to take into account the progression of  
16 the injury and how people perceive pain initially.  
17 Typically, the typical layman doesn't look at the way an  
18 injury progresses over time, and so they tend to -- they  
19 tend to oversimplify. So the fact that being struck with  
20 a bat in the chest might be painful five seconds after the  
21 injury doesn't -- doesn't negate the fact that most people  
22 -- if you actually have them break down the time frame,  
23 the sensation of a blow is more of a stunning effect as  
24 opposed to a painful effect.

25 The sensation of receiving a blow is not



1 immediately painful many times. The stunning effect is  
2 much more commonly described. Now, that's perhaps outside  
3 the realm of many -- experience of many people in the  
4 academic or the white collar world. But those people who  
5 have engaged in martial arts or collision sports may be  
6 more familiar with the -- the differentiation between the  
7 act of -- the immediate impression of receiving a blow  
8 versus the painful aftereffects that occur several seconds  
9 later.

10 Q. Dr. Williams, do you agree that being hit in the  
11 chest with a baseball bat can be extremely painful?

12 A. I suppose it can be, uh-huh.

13 Q. Is it painful if a gunshot wound hits a bone?

14 A. Can be.

15 Q. Can it be extremely painful?

16 A. Hitting the bone isn't the painful part. It's the  
17 fracture that is the painful part, the result in fracture.  
18 Fractures of the long bones typically are very painful,  
19 not so much in the -- in the -- again, in the immediate  
20 postinjury period, the first few seconds afterwards. Most  
21 people don't report pain at that time, but they start to  
22 report pain several seconds to several minutes after, as  
23 the fracture moves. So, you know, they -- the experience  
24 of pain is, again, very subjective.

25 Q. But you agree that when a gunshot wound hits a

1 bone, it can be extremely painful?

2 A. It can be.

3 Q. How many times have you personally received a  
4 gunshot wound, Dr. Williams?

5 A. One time.

6 Q. Was it painful when you were shot?

7 A. No.

8 Q. Not at any point thereafter?

9 A. I began to experience pain about three hours  
10 later.

11 Q. And were you treated for that pain?

12 A. I was.

13 Q. How so?

14 A. I was given a shot of Demerol.

15 Q. Did you have any other treatment for that pain?

16 A. No, same shot.

17 Q. Were you shot in the shoulder?

18 A. Yeah.

19 Q. And in the shoulder is not where an inmate under  
20 Utah's protocol would have the target placed, is it?

21 A. Absolutely not.

22 Q. Nor is the shoulder where an inmate under the U.S.  
23 Army's protocol would have the target placed, is it?

24 A. No.

25 Q. Did you drink alcohol the day you were shot?

1 A. I did not.

2 Q. Was it shocking when you were shot?

3 A. I was stunned, yes.

4 Q. Did you feel any adrenaline?

5 A. It's hard to say. I'm sure that there was a  
6 response, but I -- I don't recall having a sense of a  
7 panic or -- I guess I must have had something of that  
8 nature. It was a long time ago, yes.

9 Q. How old were you when you were shot?

10 A. I was 18.

11 Q. How many bullets were you shot by or with?

12 A. One bullet.

13 Q. What type of gun fired the bullet?

14 A. A pistol.

15 Q. Do you know what type of pistol?

16 A. It was a Browning automatic pistol.

17 Q. What caliber bullet were you shot with?

18 A. It was a Winchester magnum rimfire.

19 Q. And did you drive yourself to the hospital?

20 A. I did.

21 Q. Besides the narcotics medication you received, did  
22 you receive any other medical treatment?

23 A. I was kept overnight in the hospital for  
24 observation. The next morning, my family doctor came in  
25 and examined me and said, I think we should take the

1 bullet out. And so he took me to the operating suite and  
2 removed the bullet, then I was discharged home that  
3 afternoon.

4 Q. Do you agree that during an execution by firing  
5 squad, a bullet could hit a bone?

6 A. Almost certainly it will.

7 Q. Which bone?

8 A. Most likely -- well, the -- the sternum is the  
9 obvious first place the bullets will hit. Because you're  
10 dealing with high-powered rifles, these bullets will also  
11 impact the thoracic spine. It's unlikely that a rib would  
12 actually be hit, but I suppose if there's a bullet that  
13 erred by a few inches that a rib might be hit as well.

14 Q. Do bones have nerve endings?

15 A. Bones do have -- have -- do have nerves, yeah.

16 Q. And do these nerves include pain receptors?

17 A. They do.

18 Q. Does the ribcage protect the heart?

19 A. The bony cartilaginous structure of the chest --  
20 of the ribcage does protect the heart to some degree, yes.

21 Q. How many ribs are in a typical ribcage?

22 A. You've got 12 ribs on each side.

23 Q. So is that 24?

24 A. Yes.

25 Q. Can a bullet to one of these 24 ribs be very

1 painful?

2 A. It could be.

3 Q. Does the sternum protect the heart?

4 A. It lies in front of the heart, yes.

5 Q. And what is a typical sternum's width?

6 A. Typical sternum is about 5 to 7 centimeters in  
7 width in a male, and it's about 6 to 8 millimeters in  
8 depth.

9 Q. And what is a typical sternum's length?

10 A. Well, about 30 centimeters in vertical  
11 presentation.

12 Q. And do you agree that it can be very painful to  
13 have a bullet hit a sternum?

14 A. It can be. Sternal fractures can -- can be quite  
15 painful.

16 Q. Do you agree that a gunshot wound to the spine can  
17 be painful?

18 A. My understanding is that it tends not to be, but I  
19 -- the injury to the spine itself doesn't seem to be as  
20 painful in patients that I have dealt with. They don't  
21 have as much pain in that region as they do in the  
22 anterior chest.

23 Q. Is the anterior chest from the ribcage and  
24 sternum?

25 A. Yes, sir.

1 Q. Do gunshot wounds to the chest often produce  
2 spinal injuries?

3 A. Yes.

4 Q. Do you agree that all gunshot wounds are  
5 contaminated with bacteria that was brought by the bullet?

6 A. Well, that's a common misconception. There may be  
7 some bacteria on the bullet itself from being handled that  
8 will be carried with it. The bullet is certainly not  
9 sterilized by the gunshot, the active firing of the  
10 bullet. And then as the bullet passes through the skin,  
11 it will break the skin, and that opens the wound channel  
12 to bacteria that colonize the skin. Of course, if there's  
13 clothing in between, the -- there may be bacteria and  
14 other fungi and viral particles on that clothing that  
15 would contaminate the wound as well. So, yeah, those  
16 would all be -- those would all be in operation here.

17 Q. So I guess I'm not sure I understand your answer.  
18 Do you agree that all gunshot wounds are contaminated with  
19 bacteria brought by the bullet?

20 A. Theoretically, they are. We don't see a lot of  
21 infections in gunshot wounds because the -- for a lot of  
22 reasons. But there are bacteria that are brought in, no  
23 question.

24 Q. Do you see this document in front of you,  
25 Dr. Williams?

1 A. I see it.

2 Q. Is this the gunshot wounds article by Dr. Fackler  
3 that you provided to your counsel?

4 A. It looks like it.

5 Q. And do you see here, this sentence: All gunshot  
6 wounds are contaminated with bacteria?

7 A. Yes.

8 Q. Do you agree with Dr. Fackler?

9 A. Yes, and I think it's consistent with what I told  
10 you in my previous testimony. Yes, there's -- there is a  
11 degree of contamination with all gunshot wounds.

12 Q. And that's on page 201.

13 MR. MITCHELL: And we'll have that marked as,  
14 I think, Exhibit 3.

15 THE COURT REPORTER: That's correct.

16 MR. MITCHELL: Because I don't -- I don't  
17 think we marked the Utah or Army's protocol.

18 THE COURT REPORTER: You did not.

19 MR. MITCHELL: While we're at it, let's just  
20 go ahead and do that real quick.

21 (WHEREUPON, documents were marked as Exhibit  
22 Number 3.)

23 BY MR. MITCHELL:

24 Q. Dr. Williams, you recognize this document?

25 A. Scroll down a little further.

1 Q. Tell me when to stop.

2 A. Yeah, this is the Utah protocol.

3 Q. That you relied on in writing your report?

4 A. Yes, sir.

5 Q. Okay. Dated June 10, 2010?

6 A. Yes.

7 MR. MITCHELL: We can make that Exhibit 4,  
8 please.

9 (WHEREUPON, a document was marked as Exhibit  
10 Number 4.)

11 BY MR. MITCHELL:

12 Q. And, Dr. Williams, is this the U.S. Army protocol  
13 dated April 7, 1959, that you relied on in drafting your  
14 expert report in this litigation?

15 A. Yes, this is it.

16 Q. And this is the more recent of the two U.S. Army's  
17 protocols that you relied on in drafting your report in  
18 this litigation, correct?

19 A. Yes, it is. Yes, it is. I misstated the date  
20 when I said 1958. It's a 1959 document.

21 MR. MITCHELL: If we could mark this as  
22 Exhibit 5, please.

23 (WHEREUPON, a document was marked as Exhibit  
24 Number 5.)

25 BY MR. MITCHELL:



1 Q. Dr. Williams, have you ever treated an individual  
2 who was shot in the heart by a gun?

3 A. Yes.

4 Q. How many times have you treated someone who was  
5 shot in the heart by a gunshot bullet?

6 A. I don't know the exact number, 15 or 20 times  
7 perhaps, perhaps less.

8 Q. Were those people -- were any of those people in  
9 pain who had been shot in the heart?

10 A. I don't recall anybody expressing pain. They were  
11 too sick to express pain.

12 Q. Did they express any discomfort?

13 A. They were people who were fighting for their  
14 lives. They were not really conscious to the degree that  
15 you and I would consider capable of responding in a  
16 meaningful fashion.

17 Q. Did those people seem discomforted in any degree?

18 A. These are people who are in very great distress  
19 from a medical perspective. Discomfort is -- is -- I  
20 don't know if you would describe discomfort as being  
21 extraneous to the decision -- or to the -- to the  
22 expression. These are people with compromised  
23 hemodynamics. Their level of consciousness would have  
24 been impaired to some degree by the injuries they had  
25 sustained. But were they -- were they experiencing

1       discomfort? I couldn't tell you.

2       Q.       Were all of these people on pain medications by  
3       the time you saw them?

4       A.       No. Very few of them, if any, were. When people  
5       have sustained injuries of this type, your primary  
6       consideration is maintaining hemodynamic integrity. Pain  
7       medication, narcotic pain medications, are going to  
8       compromise that, so we tend not to treat that with pain  
9       medication.

10      Q.       Have you ever treated a gunshot wound to the  
11      sternum?

12      A.       That would be with the gunshot wounds to the heart  
13      that I've dealt with, yes.

14      Q.       But not a separate gunshot wound to the sternum?

15      A.       I don't recall ever seeing anybody with a sternal  
16      gunshot wound that wasn't either already dead or actively  
17      dying from the gunshot wound to the heart. I don't recall  
18      one.

19      Q.       Have you ever treated someone who was shot in the  
20      ribcage?

21      A.       Yes, several times.

22      Q.       How many times?

23      A.       Twenty-five, 30 times, more than that. No,  
24      probably more than that. Maybe 80 or 100 times.

25      Q.       How many people of those people survived?

1 A. People shot in the ribs, most of them survived.  
2 If it was -- let's put it this way: If the gunshot wound  
3 was to the lateral chest wall involving ribs or otherwise,  
4 most of those people would survive.

5 Q. Going back to the cardiovascular bundle, does the  
6 cardiovascular bundle include the arteries?

7 A. Yes, sir.

8 Q. Which arteries?

9 A. The aortic root, the aortic arch, the arteries  
10 branching off the aortic roots, the coronary arteries, the  
11 common carotid, the innominate, those arteries.

12 Q. Are there any arteries not included in the  
13 cardiovascular bundle?

14 A. Well, there's a lot of arteries in the body that  
15 aren't part of the cardiovascular bundle, yes.

16 Q. Can you name a couple of examples?

17 A. The descending aorta, femoral arteries, subclavian  
18 arteries, brachial arteries. Lots.

19 Q. And are veins also included in the cardiovascular  
20 bundle?

21 A. Yeah, I referred to those earlier. The pulmonary  
22 veins from the left and right side, the pulmonary trunk,  
23 inferior vena cava, superior vena cava, the sinus --  
24 venous sinus, those would all be venous structures.

25 Q. And are there any veins that aren't included in

1 the cardiovascular bundle?

2 A. Lots and lots. For every artery in the body,  
3 there's a corresponding vein.

4 Q. Can you give us a couple of examples of veins that  
5 aren't included in the cardiovascular bundle?

6 A. Just take those veins I already gave you, cross  
7 out artery and put veins. So subclavian, femoral, iliac,  
8 and so forth.

9 Q. What about capillaries, are those part of the  
10 cardiovascular bundle?

11 A. There are capillaries therein, within it, but  
12 they're -- those are minor structures, not anything that  
13 you would consider as relevant to a gunshot wound.

14 Q. Now, how does blood travel to the brain?

15 A. It travels out of the left ventricle into the  
16 ascending aorta, and then it's sent to the branches  
17 leading superiorly off the aortic arch with the innominate  
18 vein and the common carotid. Those are the ventricle and  
19 go forward, go up through the neck and into the -- into  
20 the head and supply the brain.

21 Q. Did you say the common carotid artery?

22 A. Yeah, I'm sorry. I'm drawing a blank. The  
23 carotid -- I'm sorry. I'm drawing a blank. There's  
24 three -- there's three arterial trunks that came out off  
25 the aortic arch that go up to the brain. For lack --

1 Q. Are those all arteries?

2 A. Yeah, those are -- those are the three arterial  
3 branches off the aortic arch that proceed superiorly and  
4 provide all the blood to the brain and the upper  
5 extremities.

6 Q. And if one of those arterial branches ceases to  
7 carry blood to the brain, can the other two continue to  
8 carry blood to the brain?

9 A. They can.

10 Q. Now, if blood supply to the brain ceases, how long  
11 does it take for loss of consciousness to ensue?

12 A. With all loss -- with loss of all circulation to  
13 the brain, it's widely considered to be 6 to 10 seconds  
14 before conscious function ceases.

15 Q. Can it be longer?

16 A. It can be.

17 Q. How much longer?

18 A. If the individual -- if the individual  
19 hyperventilates for a period of time prior to the  
20 execution, that would be longer. There's not a lot of  
21 literature to support this. The only -- the only -- and  
22 it's a rather interesting case. There was a physician in  
23 France, during the Reign of Terror, who was executed by  
24 guillotine, and he and his colleagues had a conference  
25 prior to the execution, and he -- they were -- they were

1 all genuinely interested how long the brain was conscious  
2 after the severing of the head. And so he advised his  
3 colleagues that he -- since he would be unable to speak,  
4 he would communicate to them by blinking his eyes and  
5 looking at them.

6 When the executioner raised his head out of the  
7 basket to display it to the crowd, this individual, when  
8 his head had been severed, was able to continue blinking  
9 and looking at his friends for, I believe, it was 16  
10 seconds after the -- after his head had been severed. So  
11 that's the longest we have any record of -- an antidotal  
12 record of someone being conscious and alert after there  
13 was no further circulation to the brain.

14 Q. Could it be several minutes?

15 A. No.

16 Q. Does brain death necessarily follow loss of  
17 consciousness?

18 A. No. Lots of people lose consciousness and don't  
19 die. But in this circumstance, brain death would  
20 certainly follow, yes.

21 Q. What is brain death?

22 A. I would have to look at my definition on that  
23 again, but -- because I haven't memorized it. But,  
24 essentially, that would be the loss of organized neural  
25 activity such that there's impulses being sent from the

1 brain to the rest of the body, giving the body commands  
2 and knowing how to keep functioning. That is usually --  
3 it can be measured, to some degree, by -- excuse me -- by  
4 electroencephalogram, looking at brain wave activity.

5 When there's no further brain wave activity,  
6 that's considered to be a sign of brain death. But the  
7 actual moment of brain death has never really been  
8 defined, to my knowledge, in medical literature.

9 Q. Is pulmonary edema a frequent consequence of brain  
10 death?

11 A. Pulmonary edema.

12 Q. Yes.

13 A. No. No.

14 Q. Is one of the articles you supplied your counsel  
15 with Dr. Young's Diagnosis of Brain Death?

16 A. Yeah, I believe so.

17 Q. Is this that document?

18 A. It could be. Yeah, if it's from Uptodate, yeah.

19 Q. Is this document you supplied your counsel?

20 A. I believe it is. It looks familiar.

21 Q. By Dr. Young?

22 A. Yes, sir.

23 Q. Do you see there at the very bottom of page 14 of  
24 this article where it says: Pulmonary edema and diabetes  
25 insipidus are frequent early consequences of brain death

1 and may also precipitate cardiopulmonary failure?

2 A. Yeah, this is referring to deaths in the -- the  
3 ICUs or a critical care situation where a person has  
4 experienced brain death, but still has active cardiac  
5 function.

6 Q. Do you agree that pulmonary edema can be a  
7 consequence of brain death?

8 A. In that setting, yes.

9 Q. In any other settings?

10 A. No. I mean, pulmonary edema is something that  
11 develops over hours to days. It's not something that  
12 happens rapidly as a consequence of shutdown of brain  
13 function. If you -- you're looking at a person who's been  
14 shot in the cardiovascular bundle, whose heart ceases to  
15 function, and the person dies, on autopsy, you're not  
16 going to find pulmonary edema because it takes a long time  
17 to develop.

18 MR. MITCHELL: And if we can have that  
19 article by Dr. Young marked as -- I believe we're on  
20 Exhibit 6.

21 THE COURT REPORTER: We are.

22 (WHEREUPON, a document was marked as Exhibit  
23 Number 6.)

24 BY MR. MITCHELL:

25 Q. Now, Dr. Williams, in the copy of Utah's Firing



1 Squad Execution Protocol that you relied on in drafting  
2 your report, does that protocol take in account the fact  
3 that 10 minutes after the first volley of bullets, signs  
4 of life may still be present?

5 MS. LEONARD: Object to the form.

6 THE WITNESS: I'd have to review the -- no,  
7 the Utah article -- Utah protocol has fail-safes built  
8 into it such that there would not be signs of life that  
9 late. They've got a fail-safe in there saying up to 10  
10 minutes, I believe. But the -- the protocol is very clear  
11 that if the individual shows signs of life within -- I  
12 believe it's two minutes, the leader of the execution  
13 squad is authorized to fire a second volley, which to my  
14 knowledge has never happened with any Utah execution after  
15 a second volley being fired -- sorry, a second volley has  
16 been fired a couple of times.

17 But I've never -- I've no knowledge of Utah  
18 ever refiring more than a second volley. And in, at  
19 least, one of those cases, that second volley was fired  
20 very rapidly, like within one minute.

21 BY MR. MITCHELL:

22 Q. How many cases are you aware of where Utah fired a  
23 second volley?

24 A. Sorry, can you say that again.

25 Q. How many executions in Utah do you know of that

1 required or -- or let's not use required. Excuse me. Let  
2 me -- let me rephrase.

3 How many executions in Utah had a second volley  
4 fired?

5 A. Two, to my knowledge.

6 Q. Dr. Williams, is this your expert report in this  
7 case?

8 A. It is.

9 Q. And do you see here where you're summarizing  
10 Utah's protocol?

11 A. Yes.

12 Q. You stated that signs of life will be checked for  
13 by the attending physician for a maximum of 10 minutes?

14 A. Right.

15 Q. And that if signs of life are still present, then  
16 a second volley shall be fired?

17 A. Uh-huh.

18 Q. And so do you agree that ten minutes after the  
19 first volley, signs of life may still be present and a  
20 second volley fired?

21 A. You know, there's a theoretical possibility that  
22 if you're checking every one minute, you're still seeing  
23 signs of life, you're firing a volley subsequent to that  
24 each time, which is what the protocol asks for. This  
25 would suggest that at 10 minutes this individual would've

1 received 30 rifle wounds to the chest, at least 30 rifle  
2 wounds to the cardiovascular bundle. So the probability  
3 that there would be any life signs 10 minutes into this  
4 process is fantastically improbable.

5 Q. So is it your understand of Utah's protocol that  
6 every minute, after the first three minutes, that signs of  
7 life are present as determined by the attending physician,  
8 another volley is fired up to 10 minutes?

9 A. If that -- I mean, you see the section. If, after  
10 that first volley, the condemned shows obvious signs of  
11 life, consciousness, a second volley shall be immediately  
12 fired. So, in other words, if the individual is still  
13 moving immediately after the first volley, the execution  
14 leader -- execution squad leader can authorize a second  
15 volley fired immediately.

16 They load their rifles with two rounds. The only  
17 times that those two rounds have been required have been  
18 in two executions, that I know of. In both cases, two  
19 volleys were sufficient to end the individual's life. The  
20 possibility that a third volley would be required is  
21 fantastically improbable.

22 Q. But is it possible that a sign of life may be  
23 present after 10 minutes and then a second volley is  
24 fired?

25 A. Within the realms of any kind of scientific

1 possibility, no.

2 Q. Do you know when the U.S. military last conducted  
3 an execution by firing squad?

4 A. The last execution that I'm aware of was 1947.  
5 There may have been one in early 1948 as well, but I can't  
6 confirm it.

7 Q. In preparing your expert report, did you review  
8 Tennessee's lethal injection protocol?

9 A. No, I did not.

10 Q. Have you subsequently reviewed Tennessee's  
11 execution protocol?

12 A. I have not.

13 Q. Do you know which drugs Tennessee protocol calls  
14 for?

15 A. I do not.

16 Q. Did you review any depositions from this case?

17 A. Depositions from this case? No, I did not.

18 Q. So you cannot informatively opine on the risk of  
19 operator error in Tennessee lethal injection protocol, can  
20 you?

21 A. Specifically, no, I cannot.

22 Q. And did plaintiff's counsel engage you to opine on  
23 the risk of operator error in Tennessee's lethal injection  
24 protocol?

25 A. They did not.

1 Q. Is it your view that a botched execution is one  
2 that ends up taking an hour or two?

3 A. I don't have a view on that. A botched execution,  
4 it can be defined in a lot of different ways by a lot of  
5 different people. I don't really -- I don't really have  
6 an opinion, in general. Certainly, if something that  
7 keeps somebody alive for an hour, yeah, that would be -- I  
8 think that would hit -- hit the standard of botched.

9 Q. Do you agree that when performed appropriately,  
10 lethal injection provides us with, arguably, the quickest  
11 and most humane method of deliberately ending life?

12 A. I believe it could be the most humane, if -- if  
13 performed correctly. Given that assumption, I think it's  
14 probably the most humane.

15 MR. MITCHELL: Counsel, can we take a break?  
16 It's almost lunchtime.

17 MS. LEONARD: That's fine with me. How long  
18 do you want to go for?

19 MR. MITCHELL: Thirty minutes, say 12:30  
20 Central?

21 MS. LEONARD: Sure, that's fine.

22 MR. MITCHELL: Does that work with you,  
23 Dr. Williams?

24 THE WITNESS: Fine.

25 MR. MITCHELL: Thank you.

1 THE WITNESS: Thank you.

2 (WHEREUPON, a lunch break was taken at 11:50  
3 a.m. The deposition resumed at 12:23 p.m.)

4 MR. MITCHELL: Lynne, are you prepared to  
5 proceed?

6 We are back on the record.

7 BY MR. MITCHELL:

8 Q. Dr. Williams, we just took a break for about  
9 30 minutes. During that break, did you speak with anyone?

10 A. Yes. I spoke with plaintiff's attorney, Lynne  
11 Leonard. She pointed out to me I might have made an error  
12 in my earlier testimony regarding depositions that I  
13 reviewed in preparation for this case.

14 I did review a deposition from Utah Department of  
15 Corrections in preparation for the case, but I did it at  
16 the same time as my preparation for the Nevada case, which  
17 was actually the week of the trial, so I mixed it up. But  
18 that is also in my preparation for the case. I wanted to  
19 clarify that.

20 Q. Do you know whose deposition or what deposition  
21 that was that you reviewed?

22 A. I believe that was the warden who was testifying  
23 as to the physical attributes of the Utah death chamber.

24 Q. Was that deposition taken specifically in this  
25 litigation?

1 A. I don't know if it was this litigation or it was a  
2 different -- a different case. I'm involved in four  
3 different cases right now, Mr. Mitchell. Sometimes they  
4 bleed into each other.

5 Q. Well, give me just a second.

6 And here on your expert report, do you see where,  
7 Number 4, it says you have reviewed the deposition of  
8 Steven Turley in this case?

9 A. Yes.

10 Q. Is that what we are speaking about?

11 A. I think it is, yes.

12 Q. Okay. Did Ms. Kur -- or, excuse me -- Ms. Leonard  
13 remind you of any other materials you reviewed?

14 A. No. That was the sole content of our  
15 conversation.

16 Q. Did you speak to anyone else during our break?

17 A. No.

18 Q. Did you review any materials during our break?

19 A. No.

20 Q. Dr. Williams, have you ever improperly placed a  
21 central IV line?

22 A. Do you mean like an IV line, a central line that  
23 -- improper is kind of a vague term. What are you  
24 specifically looking for, Mr. Mitchell.

25 Q. Well, have you ever placed a central IV line that

1       you had to rearrange or replace?

2       A.       I've placed a lot of central lines in 30 years,  
3       Mr. Mitchell. I'm sure I've had a few that have required  
4       -- yeah, I can think of an example in the last year or so.  
5       I placed a subclavian line -- that was the triple lumen  
6       catheter -- that I advanced was faulty or it -- it became  
7       bent during insertion and I was not able to place it in  
8       the same location. I had to go to the other side and use  
9       the other -- the contralateral subclavian vein for access.

10       That is a pretty rare occurrence, but it's  
11       happened to me, maybe, two or three times over the course  
12       of my career. That would be about it. The central lines  
13       are pretty critical; you either make them work or the  
14       patient is in real trouble. So that would be about the  
15       worst I've had to deal with.

16       Q.       Is it your testimony that you only improperly  
17       placed a central IV line two or three times over the  
18       course of your career?

19       A.       To the best of my recollection, yeah.

20       Q.       Dr. Williams, have you served as an expert witness  
21       in the Glossip versus Chandler case in Oklahoma?

22       A.       Yes, I have been engaged on that case.

23       Q.       And do Ms. Kolodinsky and Mr. Kursman also  
24       represent you in that case?

25       A.       I believe so, yes.



1 Q. And did you give testimony or a deposition in that  
2 case about a year ago, January 25th, 2021?

3 A. I don't recall it being that late, but I'll take  
4 your word for it. Yes, it was last year.

5 Q. Do you see this document?

6 A. I see it.

7 Q. Do you recall this deposition being taken in the  
8 Glossip case on January 25th?

9 A. I do.

10 Q. Can you read to me what the question was at  
11 line 23, in your deposition.

12 A. (Witness reading.) How many times have you  
13 improperly placed a central IV line in a patient.

14 Q. And what was your answer?

15 A. Well, I don't recall specifically what I said.  
16 I've had an opportunity to think about it since then,  
17 which is why I told you, two or three times, that I don't  
18 recall specifically what I said at that time. We can read  
19 what I said.

20 Q. Yeah. What did you say? What does line 25 say  
21 you said?

22 A. (Witness reading.) I didn't improperly place a  
23 central line.

24 Q. And you said: In what percent of your central  
25 lines did you improperly place a central line?

1 A. Yeah. I said: I've done thousands of central  
2 lines, I don't know. Twenty, 30, 40, 50, I don't know.  
3 Certainly less than a hundred.

4 I've had opportunity to review that, to the best  
5 of my ability, since that time and I realized that my  
6 rates of failure in central lines is well below the  
7 margin, looking at cases. Unlike gunshot wounds, which  
8 are tracked on a regular basis in procedure logs, central  
9 lines aren't.

10 I've been able to review my procedure logs and I  
11 haven't had a failed central line, improperly placed, that  
12 I put as far as back as I have been able to research.  
13 I've had two or three where I've had problems with the  
14 equipment that required me to go to another location.  
15 These are the ones that I just spoke to you about at this  
16 time.

17 MR. MITCHELL: I'm going to object to the  
18 answer as nonresponsive.

19 BY MR. WILLIAMS:

20 Q. Dr. Williams, in what percent of your central  
21 lines was the line improperly placed? In your testimony  
22 on January 25th, 2021, what did you testify was the  
23 percent of your central lines that were improperly placed?

24 A. I guess that perhaps 2 percent of my central lines  
25 have been improperly placed, because I was unprepared for

1 the question and did not have the facts in my head. I  
2 have since looked at those and the numbers are  
3 significantly less than 2 percent.

4 Q. And how were you able to look at those?

5 A. I was able to access my procedure logs at two  
6 different hospitals where I have done procedures in the  
7 emergency department. And for the period of time that we  
8 are looking back on, back to 2016, none were improperly  
9 placed. And as I looked further back, in my memory, I  
10 couldn't think of another one.

11 So improperly placed central line, Mr. Mitchell,  
12 would be one that did not cannulate the vein that was, for  
13 lack of a better word, the target of the procedure. And I  
14 can only recall a single time, back when I was a resident,  
15 where I had a central line procedure be improperly placed  
16 where I went through the subclavian line and cost me my  
17 thorax. And yet, during the same procedure, I corrected  
18 the problem and then placed it correctly.

19 So my recollection and statement, as a guess of 2  
20 percent last time, was erroneous. And I have been able to  
21 ascertain, to my satisfaction, that my successful  
22 percentage in central line placement is very close to  
23 100 percent over the course of my career.

24 I'm considered to be very good at placing central  
25 lines. And, in fact, I am usually, almost, almost always,

1 when I'm working with another physician in my emergency  
2 department, the nursing staff requests that I do the  
3 central line because my success rate is so high.

4 MR. MITCHELL: I'm going to object to that  
5 answer as nonresponsive.

6 BY MR. MITCHELL:

7 Q. How many hospitals were you able to review your  
8 records for placement of central lines?

9 A. I was able to review procedure logs for two  
10 hospitals.

11 Q. And how many hospitals have you placed central  
12 lines in, during the course of your career?

13 A. Fourteen.

14 Q. So there are 12 hospitals you were unable to  
15 review procedure logs?

16 A. That's correct.

17 Q. How many times have you improperly place a  
18 peripheral line in a patient, Dr. Williams?

19 A. Peripheral lines, I would say 2 to 3 percent.

20 Q. How many peripheral lines have you placed in  
21 patients?

22 A. Thousands.

23 Q. And do you see on page 123 of your January 25th,  
24 2021, testimony where you said that it was 10 to  
25 15 percent of peripheral IV access attempts are

1 unsuccessful?

2 A. I would say in terms of the overall average,  
3 that's correct.

4 Q. So you're well above -- or below, in a good way,  
5 average; is that your testimony?

6 A. My expertise in cannulating veins are considered  
7 extremely expert.

8 Q. Yeah. So you still improperly placed a peripheral  
9 line hundreds of times; is that correct?

10 A. Looking back, 10 to 15 percent, that would  
11 certainly be the case. I'm well below that. I would say  
12 maybe a hundred times.

13 Q. Do you see on page 121 --

14 A. That's a guess, Mr. Mitchell. These are not  
15 things that are -- that are -- that I could possibly  
16 measure.

17 Q. Did you guess in your testimony on January 25th,  
18 2021, that it was hundreds of times you did improperly  
19 place a peripheral line in a patient?

20 A. Uh-huh. Yeah, I was guessing. I've had to -- I  
21 was not prepared for the question at that time,  
22 Mr. Mitchell, and, as a consequence, I had to -- I should  
23 not have said that. I should have said I don't know and  
24 left it at that. But I have had opportunity to review my  
25 recollection, to the best of my ability, since then, and

1 I'm -- and what records I can ascertain, it's certainly  
2 been much better than the average and certainly the guess  
3 I gave you last time. It was an overestimate of failure.

4 Q. Now, Dr. Williams, switching back to page 10 of  
5 your expert report, do you see the sentence that says:  
6 Current firearms injury data show that Americans  
7 intentionally or accidentally shot by rifles die in about  
8 80 percent of cases?

9 A. Yes.

10 Q. What is the basis for that statement?

11 A. As I recall, the footnote cites the "American  
12 College of Surgeons Advanced Trauma Life Support" textbook  
13 for students.

14 Q. Is that Footnote 10?

15 A. Yes.

16 Q. Okay. And that is Footnote 10, isn't it?

17 A. Yes.

18 MR. MITCHELL: If we could have this marked  
19 as Exhibit 7, I believe we are on; is that correct?

20 THE COURT REPORTER: That's correct.

21 (WHEREUPON, a document was marked as Exhibit  
22 Number 7.)

23 BY MR. MITCHELL:

24 Q. Dr. Williams, is this the "Advanced Trauma Life  
25 Support" manual you referenced a moment ago.

1 A. It is an ATLS manual. I'm don't know if it's the  
2 one I specifically referenced.

3 Q. Well, do you know if this is the one you provided  
4 to your attorneys?

5 A. I don't know. I have taken the death trauma life  
6 support multiple times and each time they issued me a new  
7 manual. It could be. I don't know. I don't keep track  
8 of them.

9 Q. You see where it says the copyright is 2018?

10 A. Yes.

11 Q. And, in fact, in Footnote 10, you cited the 2016  
12 edition of the "Advanced Trauma Life Support" manual?"

13 A. That's what I see written here, yes.

14 Q. So you did not cite it to the basis of that  
15 statement on page 10 of your report, did you?

16 A. I cited to -- yeah, the citation may be erroneous,  
17 that's correct.

18 Q. Other than Utah's protocol for firing squad and  
19 the Army's protocol for firing squad, is there any other  
20 protocol for firing squad that you -- is there any other?

21 THE COURT REPORTER: Can you repeat your  
22 question?

23 MR. MITCHELL: Yeah.

24 BY MR. MITCHELL:

25 Q. Dr. Williams, other than Utah's protocol for

1 firing squad and U.S. Army's protocol for firing squad,  
2 did you review any other protocol for firing squad in  
3 anticipation of your expert report in this case?

4 A. I have not read or been made aware of any other  
5 protocol for firing squad, no.

6 Q. Can wind affect a firing squad shooter's ability  
7 to hit a target?

8 A. To a very small degree, yes.

9 Q. And can rain affect a firing squad shooter's  
10 ability to hit a target?

11 A. The effect of rainfall on bullets is theoretical  
12 and, as far as I know, it's never been measured. But you  
13 are correct. You are correct with that.

14 Q. Can it affect the shooter's ability to aim?

15 A. Oh, yes.

16 Q. How so?

17 A. Rainfall can reduce -- heavy rainfall can reduce  
18 visibility even in a relatively short distance. We've all  
19 been in severe rainstorms where that might happen.

20 Similarly, the accumulation of water on the sighting systems  
21 of the rifle might affect the ability of the operator to  
22 obtain a proper site picture.

23 Q. Is it possible for a rifle's site to be bumped and  
24 knocked out of alignment?

25 A. It is.



1 Q. Is it possible that shooters can be supplied with  
2 a faulty round of ammunition for a firing squad execution?

3 A. It is possible.

4 Q. Dr. Williams, turning back to your report in this  
5 case, did you insert a graphic from a Chicago Daily  
6 Tribunal article from 1938?

7 A. I did.

8 Q. Did you provide this article to your attorneys in  
9 this case?

10 A. I provided the copy that you see here, yes.

11 Q. Do you possess the complete article?

12 A. I do not.

13 Q. Have you ever?

14 A. I have never had the whole article.

15 Q. How did you receive this excerpt?

16 A. To the best of my recollection, this excerpt was  
17 obtained in the course of the death penalty case in which  
18 I was retained as an expert in the State of Ohio in 2018,  
19 I believe, might have been 2019. This case never went to  
20 deposition and -- was it Ohio? I don't recall which case  
21 it was, but it came from the federal defenders office in  
22 Ohio.

23 Q. Did the Court in that case in Ohio preclude you  
24 from testifying?

25 A. I don't recall.

1 Q. Did you plan to testify in that case?

2 A. I do not recall ever being asked to sit for a  
3 deposition or to testify at trial. No, I don't recall at  
4 all what stopped that case. It's kind of outside my  
5 wheelhouse.

6 Q. Dr. Williams, do you see this document?

7 A. I do.

8 Q. Do you see where it's titled, "U.S. Army  
9 Corrections System: Procedures for Military Executions?"

10 A. I do.

11 Q. Do you see at the bottom where it comes from the  
12 Department of Army's Headquarters in Washington, DC?

13 A. I see.

14 Q. Do you see where the date is January 17th, 2006?

15 A. I do.

16 Q. And do you see at the top of this, page 5, where  
17 it states that military executions will be by lethal  
18 injection?

19 A. I do.

20 Q. And these military procedures are from 2006?

21 A. It would appear to be so.

22 Q. And the U.S. Military procedures you rely on are  
23 from 1959 and earlier, correct?

24 A. That's correct.

25 MR. WILLIAMS: If I can have that marked as

1 Exhibit 8.

2 (WHEREUPON, a document was marked as Exhibit  
3 Number 8.)

4 BY MR. MITCHELL:

5 Q. Dr. Williams, you have treated, in your -- in the  
6 course of your time as an emergency department physician,  
7 hundreds of gunshot wounds; is that correct?

8 A. Yes.

9 Q. Were those gunshot wounds received by both men and  
10 women?

11 A. Yes. Mostly men, though.

12 Q. But women as well?

13 A. Some.

14 Q. What is the oldest person you have ever treated  
15 who received a gunshot wound?

16 A. Quite honest, I couldn't tell you. Some people  
17 have been, you know, fairly advanced, people in their  
18 seventies, perhaps, but I'm not sure.

19 Q. What is the youngest person you treated who  
20 received a gunshot wound?

21 A. I have seen gunshot wounds in individuals into  
22 their teens. I don't think I've ever seen anyone under  
23 the age of 14, 15, 16, but I might be wrong. I might be  
24 mistaken. I may have seen a pediatric wound.

25 Q. Dr. Williams, I'm going show you Exhibit 9. Do

1       you see here a post by Doc Rocket?

2       A.       Yeah, it looks like mine.

3       Q.       And did you write this?

4       A.       It appears I did.

5       Q.       Is the date here July 22nd, 2015?

6       A.       Yep.

7       Q.       And are you talking here about a surfeit of  
8       empty-headed young females who sought medical attention?

9       A.       Apparently so.

10      Q.       Did you treat any of these young men -- young  
11      females for medical attention?

12      A.       It appears so.

13      Q.       Do you see here at the top of page 2 where you  
14      stated: I have long held the opinion that if idiot young  
15      females were removed from the population, America would be  
16      a much healthier place?

17      A.       Looks like I said that.

18      Q.       Is that your opinion as a medical doctor?

19      A.       That was my opinion as an upset individual at the  
20      time.

21      Q.       Upset about something that happened in your  
22      professional capacity as a medical doctor?

23      A.       Upset in my position as a citizen, looking at the  
24      cost of things like that.

25      Q.       About a situation you encountered professionally;

1 is that correct?

2 A. Yes.

3 Q. Can you read for me the paragraph beginning  
4 "consider this?"

5 A. (Witness reading.) Consider this: The number one  
6 ER complaint in America is abdominal pain. Guess which  
7 sex accounts for 75 percent of abdominal pain in ER's is.  
8 Yep, females, most under 35. Guess what the most common  
9 cause in abdominal pain in ER's is. Constipation. Our  
10 health care system is spending billions of dollars  
11 annually to address the fact that most women have lousy  
12 dietary and bowel habits, and don't have a clue about how  
13 to deal with their own feces.

14 Q. Is it still your opinion, as a medical doctor,  
15 that most women have lousy dietary and bowel habits?

16 A. Most Americans have lousy dietary and bowel  
17 habits, women included.

18 Q. And did you also write this post at the bottom of  
19 page 4, top of page 5?

20 A. Sorry -- I think so. Can you pop it up so I can  
21 see the -- yeah, that's my post.

22 Q. Okay. What do you say in this post on July 22nd,  
23 2015?

24 A. It says -- I wrote (witness reading): Don't get  
25 me started on an intoxicated, naked, and combative female.

1 My solution to same is Haldol. Early and often.

2 Q. Do you still recommend using Haldol early and  
3 often?

4 A. Haldol, but lately we've gone to Geodon. It's  
5 more effective more quickly, and it does tend to abort the  
6 combative behavior in a more rapid fashion.

7 Q. What is Haldol traditionally used to treat?

8 A. Haldol is a phenothiazine and psychotic  
9 medication. It's used to treat psychosis.

10 Q. And you use it to treat intoxicated, naked, and  
11 combative females?

12 A. When people are intoxicated and behaving in a  
13 manner that approach psychosis -- this is alcoholic  
14 induced psychosis -- the appropriate treatment is  
15 antipsychotic medication.

16 Q. And so you do use Haldol to treat intoxicated,  
17 naked, and combative females?

18 A. As well as intoxicated, naked, and combative  
19 males.

20 Q. But you only mention females in this post; is that  
21 right?

22 A. I believe that was the topic in this case, yeah.  
23 That was the parameter of discussion.

24 MR. MITCHELL: If I didn't say it already,  
25 we'll have this marked as Exhibit 9.

1 (WHEREUPON, a document was marked as Exhibit  
2 Number 9.)

3 MR. MITCHELL: Dr. Williams, I have no  
4 further questions for you, but because we haven't received  
5 all the materials responsive to the subpoena we issued, we  
6 are going to leave your deposition open. Thank you for  
7 your time.

8 THE WITNESS: Thank you, Mr. Mitchell.

9 MR. MITCHELL: Lynne, that is all I have,  
10 unless you have anything else?

11 MS. LEONARD: Nothing from me.

12 THE COURT REPORTER: Can I have orders on the  
13 record please, copies? I'm sorry, can I have copies on  
14 the record, please, orders for the deposition.

15 Mr. Mitchell?

16 MR. MITCHELL: We would like a PDF copy,  
17 please.

18 THE COURT REPORTER: Okay. Anyone else?

19 MS. LEONARD: We will also take one on the  
20 plaintiff's side, please.

21 THE COURT REPORTER: Okay. Thank you.

22 FURTHER THE DEPONENT SAITH NOT.

23 (Proceedings ended at 12:47 p.m.)  
24  
25


C E R T I F I C A T E

STATE OF TENNESSEE:

COUNTY OF HAMILTON:

I, MELINDA CANTRELL, Court Reporter, with  
offices in Chattanooga, Tennessee, hereby certify that I  
reported the foregoing deposition of JAMES S. WILLIAMS,  
M.C., M.Sc., by machine shorthand to the best of my skills  
and abilities, and thereafter the same was reduced to  
typewritten form by me.

I further certify that in order for this  
document to be considered a true and correct copy, it must  
bear my original signature, and that any unauthorized  
reproduction in whole or in part and/or transfer of this  
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authentic, and will be in violation of Tennessee Code  
Annotated 39-14-149 Services.



Melinda Cantrell, CCR, LCR, RPR  
Elite-Brentwood Reporting Services  
LCR #872. Expiration: June 30, 2022



<hr/> <b>Exhibits</b> <hr/>	<b>10-8forums.com</b> 41:19	<b>1959</b> 101:13,20 127:23	49:19,23 50:8 54:25 60:23 118:2 119:22 121:24 122:18
<b>Ex. 01 Dr.</b> <b>James Williams</b> 2:8 7:10,11,12	<b>100</b> 32:2 40:3 70:20 103:24 120:23	<b>1976</b> 19:10	<b>2022</b> 15:2,3 82:14
<b>Ex. 02 Dr.</b> <b>James Williams</b> 2:10 43:13,14,15	<b>10:33</b> 67:10	<b>1985</b> 20:1	<b>21</b> 45:9,17 73:23 86:19
<b>Ex. 03 Dr.</b> <b>James Williams</b> 2:11 100:14,21,22	<b>10:45</b> 67:2,11	<b>1988</b> 20:2	<b>22</b> 36:4
<b>Ex. 04 Dr.</b> <b>James Williams</b> 2:13 101:7,9,10	<b>10th</b> 45:5	<b>1989</b> 19:25	<b>22-caliber</b> 36:4
<b>Ex. 05 Dr.</b> <b>James Williams</b> 2:14 101:22,23,24	<b>11</b> 80:10 81:9	<b>1990</b> 52:7	<b>22nd</b> 129:5 130:22
<b>Ex. 06 Dr.</b> <b>James Williams</b> 2:16 109:20,22,23	<b>11:50</b> 115:2	<b>1991</b> 20:18 52:8	<b>23</b> 118:11
<b>Ex. 07 Dr.</b> <b>James Williams</b> 2:18 123:19,21,22	<b>12</b> 97:22 121:14	<b>1993</b> 21:12 26:17	<b>24</b> 58:9,13 97:23, 25
<b>Ex. 08 Dr.</b> <b>James Williams</b> 2:20 128:1,2,3	<b>120</b> 5:17	<hr/> <b>2</b> <hr/>	<b>24-hour</b> 42:4,20
<b>Ex. 09 Dr.</b> <b>James Williams</b> 2:22 128:25 131:25 132:1,2	<b>121</b> 122:13	<b>2</b> 43:13,15 49:11 119:24 120:3,19 121:19 129:13	<b>24hourcampfire.com</b> 41:18
	<b>123</b> 121:23	<b>20</b> 5:24 66:19 102:6	<b>25</b> 72:23 118:20
	<b>12:23</b> 115:3	<b>2000</b> 31:17	<b>25th</b> 118:2,8 119:22 121:23 122:17
	<b>12:30</b> 114:19	<b>2003</b> 21:13 26:17 31:17 34:6	<hr/> <b>3</b> <hr/>
	<b>12:47</b> 132:23	<b>2006</b> 51:23 127:14,20	<b>3</b> 63:12 100:14,22 121:19
	<b>13</b> 67:2	<b>2007</b> 34:6 47:4	<b>3-inch</b> 73:21
	<b>14</b> 43:17 54:1 108:23 128:23	<b>2008</b> 26:9 75:12	<b>30</b> 36:9 38:3,7 39:24 59:11 98:10 103:23 112:1 115:9 117:2 119:2
	<b>15</b> 5:24 9:25 38:3 66:19 102:6 121:25 122:10 128:23	<b>2009</b> 47:1 75:12	<b>35</b> 86:11,19 130:8
	<b>15,000</b> 77:23	<b>201</b> 100:12	<b>360</b> 36:25
	<b>150</b> 32:3	<b>2010</b> 101:5	<hr/> <b>4</b> <hr/>
	<b>16</b> 66:19 107:9 128:23	<b>2015</b> 129:5 130:23	<b>4</b> 43:24 63:12 79:7 82:14 101:7,10 116:7 130:19
	<b>17th</b> 127:14	<b>2016</b> 120:8 124:11	<b>4-inch</b> 73:22
	<b>18</b> 45:20 96:10	<b>2017</b> 81:21,22 82:9,19	<b>40</b> 39:24 72:20 119:2
	<b>18th</b> 45:14,15	<b>2018</b> 47:19,21 51:13 124:9 126:18	<b>45</b> 36:9
	<b>19</b> 26:17	<b>2019</b> 49:22,23 50:11 51:4,12 126:19	<b>48</b> 80:6
	<b>1938</b> 126:6	<b>2020</b> 45:14,15 46:10,12 47:16, 17,19 49:23	
	<b>1940s</b> 81:16	<b>2021</b> 43:9 45:8,16, 17 46:2,5 47:14	
	<b>1947</b> 80:6 84:21 113:4		
	<b>1948</b> 113:5		
	<b>1950s</b> 81:14		
	<b>1957</b> 80:6,8		
	<b>1958</b> 101:20		
<hr/> <b>0</b> <hr/>			
<b>05</b> 24:13			
<b>06</b> 24:14			
<hr/> <b>1</b> <hr/>			
<b>1</b> 7:10,12			
<b>10</b> 43:9 54:25 60:23 101:5 106:13 110:3,9 111:13,25 112:3, 8,23 121:24 122:10 123:4,14, 16 124:11,15			
<b>10-8</b> 41:19 42:6			

<hr/> <p style="text-align: center;"><b>5</b></p> <hr/>	<p>14,21</p>	<p><b>acted</b> 84:7</p>	<p><b>affixed</b> 69:24 71:4</p>
<p><b>5</b> 98:6 101:22,24 127:16 130:19</p>	<p><b>abort</b> 131:5</p>	<p><b>active</b> 26:24 27:3 28:3 41:23 80:6, 24 82:11,13 84:25 99:9 109:4</p>	<p><b>afford</b> 21:3</p>
<p><b>50</b> 84:19 119:2</p>	<p><b>absent-minded</b> 12:3</p>	<p><b>actively</b> 103:16</p>	<p><b>Afghanistan</b></p>
<p><b>5260</b> 5:17</p>	<p><b>absolutely</b> 44:24 55:8 63:4 66:6 67:2 77:3 95:21</p>	<p><b>activity</b> 107:25 108:4,5</p>	<p><b>aftereffects</b> 94:8</p>
<p><b>58</b> 80:7,8</p>	<p><b>absorb</b> 70:10</p>	<p><b>actual</b> 57:25 108:7</p>	<p><b>afternoon</b> 97:3</p>
<hr/> <p style="text-align: center;"><b>6</b></p> <hr/>	<p><b>absorbant</b> 70:1</p>	<p><b>ad</b> 50:3</p>	<p><b>afternoons</b> 47:9</p>
<p><b>6</b> 37:22 38:2 39:3 98:7 106:13 109:20,23</p>	<p><b>absorptive</b> 70:9</p>	<p><b>addition</b> 16:6</p>	<p><b>age</b> 128:23</p>
<hr/> <p style="text-align: center;"><b>7</b></p> <hr/>	<p><b>academic</b> 16:8,9, 12 51:24 94:4</p>	<p><b>address</b> 5:16,17 43:25 44:3,16 71:7,13 130:11</p>	<p><b>agencies</b> 74:18, 22,25 75:4</p>
<p><b>7</b> 37:23 38:3 98:6 101:13 123:19,22</p>	<p><b>academy</b> 74:14</p>	<p><b>adequately</b> 29:10</p>	<p><b>agree</b> 7:3 35:7 37:21 64:5 65:9</p>
<p><b>75</b> 130:7</p>	<p><b>acceptable</b> 73:18</p>	<p><b>administration</b></p>	<p>74:3,6 76:25 77:3 78:12,16,18</p>
<hr/> <p style="text-align: center;"><b>8</b></p> <hr/>	<p><b>accepted</b> 20:5 48:2 65:23</p>	<p>25:6</p>	<p>88:18,22 89:17 91:9,24 92:13</p>
<p><b>8</b> 98:7 128:1,3</p>	<p><b>access</b> 10:24</p>	<p><b>administrative</b></p>	<p>94:10,25 97:4 98:12,16 99:4,18</p>
<p><b>80</b> 32:7 65:9 103:24 123:8</p>	<p>117:9 120:5 121:25</p>	<p>73:1 84:8</p>	<p>100:8 109:6 111:18 114:9</p>
<p><b>86</b> 20:1</p>	<p><b>accessed</b> 42:18</p>	<p><b>administrators</b></p>	<p><b>ahead</b> 4:14 46:4 100:20</p>
<hr/> <p style="text-align: center;"><b>9</b></p> <hr/>	<p><b>accident</b> 60:7</p>	<p>48:25</p>	<p><b>aid</b> 60:17</p>
<p><b>9</b> 128:25 131:25 132:2</p>	<p><b>accidental</b> 61:20</p>	<p><b>admission</b> 22:4</p>	<p><b>aim</b> 29:2,12,14,16 125:14</p>
<p><b>90-degree</b> 69:9</p>	<p><b>accidently</b> 123:7</p>	<p><b>admitted</b> 21:18</p>	<p><b>aimed</b> 36:6</p>
<hr/> <p style="text-align: center;"><b>A</b></p> <hr/>	<p><b>accidents</b> 60:13</p>	<p><b>adrenaline</b> 96:4</p>	<p><b>aiming</b> 36:2,22,24</p>
<p><b>a.m.</b> 67:10,11 115:3</p>	<p><b>accomplish</b> 66:24</p>	<p><b>advanced</b> 52:24 117:6 123:12,24 124:12 128:17</p>	<p><b>air</b> 22:15 39:16</p>
<p><b>ABCS</b> 32:15</p>	<p><b>accomplished</b> 66:2</p>	<p><b>adversary</b> 28:25</p>	<p><b>airway</b> 32:14,20, 21</p>
<p><b>abdominal</b> 130:6, 7,9</p>	<p><b>account</b> 41:5,6 93:15 110:2</p>	<p><b>advertised</b> 46:20</p>	<p><b>airway's</b> 32:15</p>
<p><b>Aberhart</b> 19:4</p>	<p><b>accounts</b> 41:8, 10,12 130:7</p>	<p><b>advice</b> 8:3</p>	<p><b>Alberta</b> 19:5 20:22</p>
<p><b>Abilene</b> 23:15</p>	<p><b>accumulating</b> 58:10</p>	<p><b>advised</b> 107:2</p>	<p><b>alcohol</b> 95:25</p>
<p><b>ability</b> 13:20 29:13 119:5 122:25 125:6,10,</p>	<p><b>accumulation</b> 125:20</p>	<p><b>advisory</b> 83:12</p>	<p><b>alcoholic</b> 131:13</p>
	<p><b>accuracy</b> 35:25 86:24</p>	<p><b>Advocate</b> 82:7 83:11</p>	<p><b>alert</b> 35:4 107:12</p>
	<p><b>achievable</b> 55:11</p>	<p><b>affect</b> 11:16,18 13:23 40:24 125:6,9,14,21</p>	<p><b>Alex</b> 5:2 14:5,11</p>
	<p><b>achieved</b> 65:16, 25 66:1</p>	<p><b>affected</b> 13:9 34:17</p>	<p><b>Alexandria</b> 9:14</p>
	<p><b>act</b> 31:10 76:2,8 94:7</p>	<p><b>affecting</b> 47:13 90:20</p>	<p><b>alignment</b> 125:24</p>
		<p><b>affix</b> 54:10</p>	<p><b>alive</b> 66:8 114:7</p>
			<p><b>alluded</b> 79:2</p>
			<p><b>alternate</b> 85:14, 16</p>

**amalgam** 30:22  
**America** 129:15  
 130:6  
**American** 26:5,8,  
 23 123:11  
**Americans** 123:6  
 130:16  
**ammunition**  
 40:22 61:7 62:21,  
 22 88:1 126:2  
**amount** 9:25  
 28:11 36:9 86:4  
**Ana** 5:2  
**Anahata** 23:18  
 41:7  
**anatomic** 18:10  
 91:11,14  
**anatomically**  
 56:12  
**anatomy** 18:10,  
 12,17,20,22 24:1,  
 4,6,11,13,17,19  
 28:20 40:16 41:7  
 49:20,21 50:11,14  
 51:5,17,19 56:8  
**anesthesiologist**  
 13:13 21:2  
**anesthesiology**  
 12:21 21:1  
**angle** 36:5,6,10,  
 11,22,25 69:10  
 91:3  
**angles** 37:3  
**Annals** 37:10  
**annual** 47:4  
**annually** 73:16  
 130:11  
**answering** 7:2  
**anterior** 39:15  
 63:14 98:22,23  
**anticipation**  
 17:3,15,16 18:4,  
 14 19:1 125:3  
**antidotal** 107:11

**antipsychotic**  
 131:15  
**anymore** 42:3  
 51:16  
**aorta** 104:17  
 105:16  
**aortic** 64:20 65:2  
 104:9,10 105:17,  
 25 106:3  
**apex** 64:19,21  
**apologize** 26:18  
 51:4  
**Apparently** 129:9  
**appearing** 4:20  
**appears** 56:9  
 65:20 129:4,12  
**Appendix** 79:20  
**apples** 56:7 90:4  
**apply** 19:21  
**approach** 131:13  
**appropriately**  
 114:9  
**April** 46:1 101:13  
**ar15.com** 42:13  
**ar15.com.** 41:20  
**arch** 64:21 104:9  
 105:17,25 106:3  
**area** 30:4 53:14  
 91:10  
**areas** 90:23  
**arguably** 16:17  
 114:10  
**arguments** 12:12  
**Arizona** 53:11  
**Arkansas** 48:3,4,  
 21 49:6  
**Armed** 83:24 89:9  
**Army** 78:21 79:25  
 80:3,13,15,19  
 81:1,2,4,5,16  
 82:1,3 101:12  
 127:8

**Army's** 79:18,21  
 81:10 84:1 85:17  
 86:9 95:23 100:17  
 101:16 124:19  
 125:1 127:12  
**arrear** 80:9  
**arrhythmias** 60:4  
**arterial** 22:17  
 105:24 106:2,6  
**arteries** 65:3  
 104:6,8,9,10,11,  
 12,14,17,18 106:1  
**artery** 105:2,7,21  
**article** 100:2  
 108:24 109:19  
 110:7 126:6,8,11,  
 14  
**articles** 24:14  
 37:9 108:14  
**arts** 94:5  
**ascending**  
 105:16  
**ascertain** 120:21  
 123:1  
**asks** 111:24  
**aspects** 10:3 13:2  
**assemble** 54:12  
 61:6  
**assertion** 88:21  
**assessment**  
 21:25 32:12,14  
**assistance** 50:3  
**assistant** 33:21  
 48:23 49:19  
**assisted** 50:8  
**association**  
 26:22 27:15 29:24  
 30:3,5,8 48:7 60:3  
**associations**  
 26:11,19 27:4  
**assumption**  
 87:14,22,23,25  
 114:13  
**assumptions**  
 87:12,17

**astray** 70:16  
**atlas** 18:20,22  
**ATLS** 124:1  
**atria** 63:15 65:1  
**atrial** 64:20  
**attach** 44:25  
**attached** 79:11,  
 19,22  
**attachment** 8:11  
 79:13  
**attempting** 31:10  
**attempts** 121:25  
**attend** 19:3 25:10,  
 11 47:4  
**attended** 10:22  
 19:4 46:24,25  
 47:3 50:4 53:10  
 61:14,16,19 75:4,  
 6  
**attending** 47:11  
 111:13 112:7  
**attention** 11:16  
 129:8,11  
**attorney** 4:4 8:1,  
 2,5,19,20,23,24  
 9:2 115:10  
**attorneys** 9:5,7  
 10:9,11 14:2,4  
 15:13,16 16:23  
 81:6 124:4 126:8  
**attributes** 115:23  
**Atyia** 4:21  
**August** 42:21  
**author** 16:10  
**authorize** 112:14  
**authorized** 73:14  
 82:3 84:25 110:13  
**authors** 37:18  
**automatic** 96:16  
**autopsy** 109:15  
**average** 56:16  
 122:2,5 123:2



37:3 70:4,6,11  
87:10 96:11 97:9,  
10 110:3 125:11

**bumped** 125:23

**bunch** 41:16

**bundle** 63:9 64:8,  
11,16,24,25 65:8  
66:14 87:7 89:2,  
11 90:3,8,23 91:1,  
4,12,20 104:5,6,  
13,15,20 105:1,5,  
10 109:14 112:2

**burns** 57:12 92:6

**business** 67:20

**bystander** 60:16

---

## C

---

**C-L-Y-D-E** 5:18

**calendar** 45:18

**caliber** 62:8,11  
69:8 96:17

**call** 4:25 14:7,14  
21:15,16 41:12,13  
44:7,10

**called** 5:10 22:18  
23:18 24:1 26:12  
40:17 41:20 90:9

**calls** 14:16,17  
15:5,6,7,9 113:13

**Calvary** 19:5,8  
20:6,7,9,19 52:7

**Cambridge** 18:23

**Campfire** 42:4,21

**Canada** 19:5  
26:13,14,16

**cancer** 58:7

**cannulate** 120:12

**cannulating**  
122:6

**capabilities**  
33:10 74:2 86:18

**capability** 33:12

**capable** 35:3  
62:15 102:15

**capacity** 60:15  
83:13 86:7 129:22

**capillaries** 105:9,  
11

**car** 28:21

**card** 90:22

**cardiac** 60:3  
109:4

**cardio** 57:6 59:21

**cardiopulmonar  
y** 109:1

**cardiovascular**  
63:9 64:8,11,16,  
24,25 65:8,11,13,  
17 66:13,21 87:7,  
9 89:2,11 90:3,8,  
23 91:1,4,12,20  
104:5,6,13,15,19  
105:1,5,10 109:14  
112:2

**care** 12:20 25:7,9,  
12 34:23 68:20,23  
109:3 130:10

**career** 5:25 33:9  
40:5 117:12,18  
120:23 121:12

**carotid** 104:11  
105:18,21,23

**carried** 99:8

**carry** 31:10 77:9,  
17 106:7,8

**cartilaginous**  
97:19

**case** 4:19,25 9:1  
10:14 14:2,20  
15:22,24 17:17,  
21,22,23,24 33:13  
43:1 45:2,10,11,  
12,13,23 60:17  
61:22 62:7 63:25  
67:16,21 68:4,8  
79:3,6 81:18,19,  
20,21 106:22  
111:7 113:16,17  
115:13,15,16,18  
116:2,8 117:21,  
22,24 118:2,8  
122:11 125:3  
126:5,9,17,19,20,

23 127:1,4 131:22

**cases** 39:23 60:16  
61:11 69:20  
110:19,22 112:18  
116:3 119:7 123:8

**casualties** 25:12

**casualty** 25:9

**catch** 52:19

**catheter** 117:6

**causing** 88:11

**cava** 65:5 104:23

**cavity** 90:12,16,  
20

**cease** 65:19 66:9  
87:9 91:22

**ceased** 66:12

**ceases** 65:21  
106:6,10,14  
109:14

**cell** 6:7 14:16

**cells** 66:9

**Center** 23:19

**Center-fired** 62:8

**centimeters**  
98:6,10

**central** 39:14  
56:19 65:19 67:3  
90:23 114:20  
116:21,22,25  
117:2,12,17  
118:13,23,24,25  
119:1,6,8,11,20,  
23,24 120:11,15,  
22,24 121:3,8,11

**certainty** 49:5  
70:20 73:18 82:15  
84:13

**certificate** 28:11

**certification**  
12:21 26:13

**certifications**  
47:25

**certified** 26:2,3,4,  
5,7,10,14,15  
27:12,14 29:23,25

30:12 73:24,25  
74:7

**cessation** 88:11

**chair** 69:24,25  
70:15 71:4,23

**chamber** 69:1,17,  
20 115:23

**chambers** 69:6

**chances** 37:22

**Chandler** 117:21

**change** 12:23,24  
13:5

**changed** 13:4  
54:24 60:22

**channel** 99:11

**check** 42:23

**checked** 67:15  
111:12

**checking** 111:22

**chemistry** 20:14

**chest** 22:13,15,16  
31:20 38:15,21  
39:8,13,14,23,25  
59:7 63:23 64:3,  
13 65:10 73:22  
88:23 89:15,24  
90:1,6,9,11,14,23,  
25 91:3,7,10  
92:16,21,23,25  
93:2,3,4,7,8,13,20  
94:11 97:19  
98:22,23 99:1  
104:3 112:1

**Chicago** 126:5

**children** 21:4

**choice** 92:3

**chose** 9:17

**circle** 73:22

**circulation** 66:4,  
11,13 106:12  
107:13

**circulatory** 32:17

**circumstance**  
107:19

**circumstances**

31:7 34:9 46:8  
57:2 59:20

**citation** 124:16**cite** 124:14

**cited** 9:8 16:1  
78:19 124:11,16

**cites** 123:11**citizen** 129:23**Citizens** 22:25**civilian** 24:2

**clarify** 6:19,24  
14:17 115:19

**class** 49:18,19  
50:17

**classes** 50:4  
51:11

**classroom** 28:19

**clear** 11:21  
110:10

**clearer** 51:1**clinic** 23:14,18**clinical** 21:14**clinics** 23:14,17

**close** 23:16 38:19  
65:10 120:22

**closely** 64:14**cloth** 63:10**clothing** 99:13,14**clue** 130:12**Clyde** 5:15,17**co-counsel** 4:20**Cody** 4:21**collar** 94:4**collateral** 69:22

**colleague** 49:20  
50:8

**colleagues** 5:1,4  
11:19 52:23  
106:24 107:3

**collection** 64:12

**college** 19:6  
26:14,16,23  
123:12

**collision** 94:5

**collisions** 57:5  
59:23

**Colonel** 18:7  
75:20,23

**colonize** 99:12**color** 12:16

**colored** 12:14  
16:2

**combat** 18:8 25:9

**combative**  
130:25 131:6,11,  
17,18

**commands** 108:1

**comment** 17:1  
38:11

**comments** 76:1

**commission**  
83:6

**commit** 61:7

**common** 18:20  
62:21,22,23 90:18  
99:6 104:11  
105:18,21 130:8

**commonly** 18:21  
62:9 66:1 94:2

**communicate**  
107:4

**communication**  
10:22 14:11  
83:11,20

**communications**  
8:23,24 9:1,8  
10:12,17 14:13

**community** 5:1  
22:4 53:14 83:19

**company** 24:1**compare** 56:7

**compared** 59:12  
92:11

**comparing** 90:4

**comparison** 59:2

**compendium**  
10:5

**competition** 28:3  
29:21 30:10

**competitive**  
28:12

**competitor** 28:2,  
3

**complaint** 130:6

**complete** 9:4  
20:21 32:24 88:11  
126:11

**completely** 88:19  
90:5 91:5

**complex** 22:5

**complexities**  
61:8

**components**  
65:7

**comprise** 64:15  
65:4

**comprises** 65:1

**compromise**  
103:8

**compromised**  
102:22

**computer** 6:4,10,  
13 8:16

**concentrated**  
65:21

**concept** 59:8

**concern** 12:25  
36:2

**concerned** 33:1

**conclude** 54:2  
55:2

**concluded** 58:17

**concluding**  
60:25 84:24 87:3

**conclusion**  
54:20,24 60:19,22  
78:22 85:11

**conclusions**  
59:1

**condemned** 54:8  
61:4 63:1,2,5  
69:23 70:7 71:4  
72:2 73:22 86:10,  
13 87:2 112:10

**condition** 13:22**conditioned** 76:7**conditions** 22:1

**conduct** 23:25  
24:2 49:23 50:1,  
14 51:13 76:20

**conducted** 49:12,  
17,20 50:12 51:7,  
9 72:18 75:2,10  
113:2

**conducting** 50:9  
86:21

**conducts** 83:20

**conference**  
46:24 47:1,3,20,  
21 51:10 106:24

**conferences**  
46:14,16,23  
47:14,16,22

**confidentiality**  
12:2

**confirm** 113:6

**confounding**  
49:7

**confusing** 13:11  
49:3 79:5

**congestive** 58:11**Congress** 83:10**conjunction** 8:2

**conscious** 32:13  
35:3 92:23 102:14  
106:14 107:1,12

**consciousness**  
102:23 106:11  
107:17,18 112:11

**consensus** 65:24

**consequence**  
108:9 109:7,12



122:22  
**consequences**  
108:25  
**considerably**  
29:21,22 56:15  
61:11  
**consideration**  
103:6  
**considered** 12:8  
22:12 53:16 65:22  
79:8 80:1,18,24  
81:7 106:13 108:6  
120:24 122:6  
**consist** 28:18  
32:9  
**consistent** 89:20  
100:9  
**consists** 69:25  
**constant** 66:8  
**Constipation**  
130:9  
**constitutes** 8:18  
**constructing**  
71:17  
**construction**  
69:7  
**consultation**  
25:5  
**contaminate**  
99:15  
**contaminated**  
99:5,18 100:6  
**contamination**  
100:11  
**content** 116:14  
**contention** 60:21  
**context** 81:3 92:2  
**continue** 106:7  
107:8  
**contractor** 23:7  
**contralateral**  
117:9  
**contribute** 41:21

**control** 32:20  
**conversation**  
116:15  
**conversations**  
84:24  
**conveying** 56:1  
**coordinator** 30:4  
**copies** 8:8 132:13  
**copy** 18:23  
109:25 126:10  
132:16  
**copyright** 124:9  
**coronary** 104:10  
**correct** 9:3 16:11  
18:1 23:11,12  
50:9,10 53:21  
71:2 79:9,10  
80:16 100:15  
101:18 121:16  
122:3,9 123:19,20  
124:17 125:13  
127:23,24 128:7  
130:1  
**corrected** 120:17  
**corrections** 40:9,  
11 54:10,13 61:6  
68:16 72:8 77:5  
115:15 127:9  
**correctly** 38:11  
114:13 120:18  
**corridor** 39:14  
**cosmetic** 23:21,  
22  
**cost** 120:16  
129:24  
**counsel** 44:12,19  
100:3 108:14,19  
113:22 114:15  
**county** 5:17 23:2  
34:7  
**couple** 6:15 14:12  
15:6,7 16:7,16  
17:19 18:10 22:25  
23:4 41:25 47:1  
71:21 104:16  
105:4 110:16

**courses** 19:23  
73:8  
**Court** 4:7,8,12  
100:15,18 109:21  
123:20 124:21  
126:23 132:12,18,  
21  
**cover** 17:13  
**covered** 21:19  
30:17 51:6,10  
**covers** 71:11  
**COVID** 42:20  
**craft** 44:19  
**crafted** 44:22  
**creases** 90:9  
**create** 56:4  
**credential** 19:14  
**criminal** 76:12  
**critical** 109:3  
117:13  
**cross** 105:6  
**crowd** 107:7  
**crush** 56:17  
**CT** 33:3  
**culmination** 66:3  
**Cumming** 20:10  
**current** 25:25  
78:20,24,25 79:2  
80:7,11,25 81:3,  
23 123:6  
**curriculum** 8:9  
28:20 74:14  
**curvature** 36:18,  
23  
**cutdowns** 22:17  
**CV** 44:25 45:2  
79:14,16,23  
**cycles** 66:10  

---

**D**

---

**Dade** 39:2

**Daily** 126:5  
**damage** 33:5  
69:22  
**Danny** 81:21  
**data** 38:25 123:6  
**date** 45:2,4,6,18,  
24 101:19 127:14  
129:5  
**dated** 43:9 101:5,  
13  
**dates** 80:3  
**Dave** 75:20  
**David** 5:6 76:21  
**day** 40:24 47:13  
95:25  
**days** 21:16 109:11  
**DC** 127:12  
**dead** 57:24 61:22  
103:16  
**deadly** 24:3 31:10  
**deal** 36:23 90:19  
117:15 130:13  
**dealing** 88:13  
97:10  
**dealt** 98:20  
103:13  
**dean** 4:21 16:18  
**death** 9:22 10:4,  
23 12:17 13:3,16  
39:5 44:6 54:14,  
16 55:3,5,8,12,14,  
18,21,25 56:23  
57:3,9,10,11,12,  
13,16 58:4,8,13,  
18,22 59:5,10,16  
60:20 61:5,13,14,  
15,17 65:18,22,  
23,24,25 66:18  
68:25 76:9 78:12,  
16 86:2 87:5,11,  
19 88:6 107:16,  
19,21 108:6,7,10,  
15,25 109:4,7  
115:23 124:5  
126:17  
**deaths** 55:16

57:5,17,25 59:24,  
25 109:2

**decades** 26:18

**deceased** 33:12

**December** 42:24

**decided** 19:21  
34:8

**decision** 102:21

**deer** 62:10

**deer-hunting**  
62:16

**defend** 20:5

**defendant** 4:19

**defendants** 62:6  
68:4,8,11,13

**Defender** 5:2

**defenders** 126:21

**defense** 20:8

**Defensive** 30:5,8

**defer** 52:23

**deferred** 53:12

**define** 87:13,24

**defined** 91:14  
108:8 114:4

**definition** 54:7  
55:13 65:23  
107:22

**definitive** 28:24

**degree** 9:24 19:8,  
10 20:3,11 52:9,  
16 73:18 82:15  
86:24 97:20  
100:11 102:14,17,  
24 108:3 125:8

**degrees** 20:6  
36:9,10 92:8

**deliberately**  
114:11

**delivery** 66:5,14,  
23

**Demerol** 95:14

**density** 35:23  
36:1,15

**department** 22:1  
25:7,18,20 27:20,  
21 28:6 30:13  
34:11 38:23 40:9,  
11 51:7 54:10,13  
56:22 57:14 61:6  
68:15 72:8 75:7  
77:5 115:14 120:7  
121:2 127:12  
128:6

**department's**  
29:9

**depending** 38:24

**depends** 74:11

**DEPONENT**  
132:22

**deposition** 5:21  
6:17 7:21 8:7  
11:10 14:21 45:10  
49:2 67:11 68:1  
69:19 115:3,14,  
20,24 116:7  
118:1,7,11 126:20  
127:3 132:6,14

**depositions** 5:24  
113:16,17 115:12

**depth** 33:23 98:8

**descending**  
104:17

**describe** 102:20

**desirable** 65:13

**destruction**  
65:25

**destructive** 86:7

**details** 11:23  
18:11

**determined**  
112:7

**develop** 109:17

**developed** 11:22  
80:7 84:8

**develops** 109:11

**Di** 16:5,7,9,24  
17:11 18:3

**diabetes** 108:24

**diagnosis** 21:25  
108:15

**diameter** 62:12  
63:12

**die** 39:22 40:6  
57:22,23,24 58:6,  
14 59:4,16,17  
60:11 107:19  
123:7

**died** 32:4 38:20  
57:4 60:7 61:22,  
23

**dies** 58:9 109:15

**dietary** 130:12,15,  
16

**difference** 75:13,  
16,17,19 85:21,23  
86:18

**differences** 84:5

**differentiation**  
94:6

**differently** 58:8

**differs** 81:10

**difficult** 35:17,22  
36:15,19,21 39:12  
61:4,5 77:1

**dignity** 63:24

**direct** 69:8 88:6,  
19

**directive** 69:8

**directly** 55:23  
93:2

**disability** 32:19

**discharge** 22:3

**discharged** 97:2

**discomfort**  
102:12,19,20  
103:1

**discomforted**  
102:17

**discussed** 18:15  
23:24 30:15 84:22

**discussion** 47:9,  
12 131:23

**discussions**  
11:19 47:6

**disease** 57:5

**disfiguring** 63:24

**display** 107:7

**disposition** 22:3  
33:6

**dispute** 34:9

**dissimulate**  
53:15

**distance** 73:23  
86:20 125:18

**distances** 86:16,  
25

**distinction** 53:18

**distress** 102:18

**Doc** 42:5,17 129:1

**doctor** 50:18  
96:24 129:18,22  
130:14

**document** 7:11,  
14,18 10:21 43:5,  
14 99:24 100:24  
101:9,20,23  
108:17,19 109:22  
118:5 123:21  
127:6 128:2 132:1

**documented**  
37:2

**documents** 6:9,  
11 7:23,25 8:2,4,  
10,16,22 9:8,11,  
13,16,20 10:3,7,  
12,15,17 15:19  
16:1,2,3 18:3,4  
84:15 100:21

**Dogs** 60:18

**dollars** 130:10

**domestic** 34:9,13

**doodling** 35:16

**door** 67:25

**double** 78:15  
85:23

**dozen** 58:2 60:10  
93:11



**dozens** 59:19  
92:20,24

**drafting** 9:9  
101:13,17 110:1

**draining** 22:15

**draw** 58:22

**drawing** 105:22,  
23

**drawn** 85:11

**drink** 95:25

**drive** 96:19

**driving** 41:14

**drop** 55:17

**drug** 57:9

**drugs** 13:15,16  
113:13

**drunk** 34:7

**dues** 26:25

**duly** 5:10

**duties** 25:4

**duty** 25:20 74:1

**dying** 58:12,25  
59:12 65:18  
103:17

---

## E

---

**e-mails** 8:17,19  
14:14,17 67:15

**earlier** 59:21 61:3  
81:2,5,23 82:1  
104:21 115:12  
127:23

**earlobes** 34:18

**early** 108:25  
113:5 131:1,2

**earning** 83:22

**easy** 67:6

**edema** 108:9,11,  
24 109:6,10,16

**edge** 92:4

**edged** 57:9

**edition** 124:12

**education** 19:12,  
13,16 42:20

**effect** 89:3 93:23,  
24 94:1 125:11

**effective** 76:24  
131:5

**effects** 53:17  
89:10 91:16

**efficacy** 12:15  
13:2 43:22 44:7

**efficiency** 13:3  
43:22 44:10

**elected** 34:9

**electrical** 56:18  
57:11

**electrocuted**  
61:20

**electrocution**  
61:13,14,15,16,18

**electroencephalogram** 108:4

**embedded** 69:6

**emergency** 21:7,  
9,11,13,19,21,23  
22:1,11,23 23:10  
25:19 31:8 34:1,  
22 37:10 38:23  
39:8 56:22 57:14,  
23 120:7 121:1  
128:6

**emergent** 21:25  
32:22

**emphasis** 20:23

**employed** 54:12

**employees** 24:6,  
9

**employment**  
25:25

**empty-headed**  
129:8

**enable** 64:3

**encountered**  
129:25

**end** 4:7,14 17:13  
112:19

**endeavor** 76:11

**ended** 132:23

**ending** 114:11

**endings** 97:14

**endocrinology**  
19:25 20:3,25

**ends** 114:2

**energy** 36:5 62:16  
66:10 70:11 86:1,  
6

**enforcement**  
24:3 40:23,24  
41:17,20 47:20,21  
62:23 73:7 78:9

**engage** 44:19  
113:22

**engaged** 43:20,  
25 44:2,12,14,16  
54:12 94:5 117:22

**enormous** 10:5  
75:16,19

**ensue** 106:11

**entails** 54:19

**enter** 19:18,24

**entered** 20:2,4,9

**entire** 8:13 9:14

**environment**  
25:8 30:10

**equipment**  
119:14

**equivalent** 26:13  
92:24

**ER** 11:23 130:6

**ER's** 130:7,9

**erred** 97:13

**erroneous**  
120:20 124:16

**error** 78:13,17  
80:23 113:19,23  
115:11

**escapes** 11:20

**Esquivel** 5:6 14:6

**essentially** 9:23  
70:9 107:24

**established** 73:9

**estimate** 32:4  
39:3,12,21 63:9

**estimates** 66:20

**evaluate** 32:12

**event** 49:8

**evidence** 85:8

**exact** 31:18 102:6

**examination**  
5:12 21:25

**examined** 96:25

**examples** 57:8,13  
62:18 76:10  
104:16 105:4

**exceed** 74:23

**exception** 56:2  
60:1,2

**exceptions** 60:2

**excercise** 68:20

**excerpt** 126:15,16

**excuse** 22:14  
42:2 108:3 111:1  
116:12

**execute** 62:7  
68:4,8,13 72:24

**executed** 84:13,  
18 87:8 106:23

**executing** 63:21

**execution** 12:7,  
10,25 13:6 43:23  
44:5,8,17,20,22  
48:19 54:3,9,17,  
21 55:2 60:19,25  
61:1,7,9,10,16,24  
62:1,3,25 65:14  
66:22 68:19 69:2,  
9,11,15,17,20  
70:18 71:14 72:4,  
14 77:9,18 78:20,  
22,23 79:9 80:12  
82:2,3,11,14 84:1,  
25 85:1 86:21

87:4,18 88:19  
97:4 106:20,25  
110:1,12,14  
112:13,14 113:3,  
4,11 114:1,3  
126:2

**executioner**  
107:6

**executioners**  
73:4

**executions**  
12:14,23 72:11,17  
77:5 79:19 84:9,  
20 110:25 111:3  
112:18 127:9,17

**exercised** 68:23

**exhausted** 66:16

**exhibit** 7:10,11  
43:13,14 56:19  
73:5 100:14,21  
101:7,9,22,23  
109:20,22 123:19,  
21 128:1,2,25  
131:25 132:1

**exists** 92:1

**exit** 37:4

**expedient** 33:2  
54:15 63:6

**experience** 28:12  
29:21 30:18 71:18  
72:24 73:1 75:16  
78:8 89:21 94:3,  
23 95:9

**experienced**  
73:5 109:4

**experiences** 56:4

**experiencing**  
102:25

**expert** 6:8,10 9:9,  
17,18 10:13,14  
12:17,19 13:8,9  
14:19 15:24 16:18  
27:6,11,12,19,25  
28:6,7,9 29:11,19  
30:15 40:8,10  
43:1,7 44:25 45:5,  
8,9 46:5,9 48:2  
52:14,15,23 53:1,  
4,6,9,12,17,20

54:1 75:24,25  
78:19 82:23 83:8  
89:5 101:14 111:6  
113:7 116:6  
117:20 122:7  
123:5 125:3  
126:18

**expertise** 27:22  
28:14 30:21 52:22  
53:14 122:6

**expertly** 78:9

**experts** 10:18  
47:7,10 52:17,21

**explain** 50:23

**express** 102:11,  
12

**expressing**  
102:10

**expression**  
102:22

**extend** 71:22 86:5

**extensive** 14:9

**extent** 53:8

**extraneous**  
102:21

**extreme** 64:18,19

**extremely** 55:10,  
11,12,14 69:16  
70:16,18 88:2  
91:25 92:13  
94:11,15 95:1  
122:7

**extremities** 106:5

**eyes** 107:4

---

**F**

---

**face** 58:21 63:24

**Facebook** 41:5,6

**facetious** 53:7

**facilities** 35:6

**facility** 22:5

**Fack** 16:16

**Fackler** 16:17  
17:2,5,9,10 18:3

83:9 100:2,8

**Fackler's** 16:21  
17:19

**fact** 53:13 73:19  
79:3 80:21 85:12  
93:19,21 110:2  
120:25 124:11  
130:11

**facts** 12:11,12,16  
18:1 87:16 120:1

**fail-safe** 110:9

**fail-safes** 110:7

**failed** 119:11

**failure** 57:3,6  
58:11 109:1 119:6  
123:3

**fair** 11:11 29:16,18

**fairly** 13:2 29:7  
35:12 128:17

**falling** 88:9

**familiar** 16:6 78:9  
94:6 108:20

**familiarity** 52:16  
68:15

**family** 21:5,15  
26:5,8,14,16  
96:24

**fantastically**  
112:4,21

**fashion** 102:16  
131:6

**fast** 88:13

**faulty** 88:1 117:6  
126:2

**feasibility** 54:7,  
19 71:17

**feasible** 25:10  
44:9 54:2,6,8,18,  
21 61:1 68:3,7,13  
72:3 78:22,25  
79:1

**feces** 130:13

**federal** 5:1 126:21

**feel** 96:4

**feels** 92:16

**feet** 73:23 86:11,  
15,19

**fellow** 5:3 13:12  
34:7 49:4 82:6

**felt** 93:8

**female** 130:25

**females** 129:8,11,  
15 130:8 131:11,  
17,20

**femoral** 104:17  
105:7

**fewer** 40:2,3

**fides** 8:9 48:5

**field** 39:4 52:16,24  
83:24 89:9

**fighting** 102:13

**file** 8:13,16,18  
11:7 16:13

**files** 17:5,6,7  
85:10

**fillers** 23:21

**final** 63:15 65:23

**finances** 21:3

**find** 33:3,4 37:11,  
12 76:25 85:4,5  
109:16

**fine** 7:1 67:4,5  
114:17,21,24

**finger** 28:10

**fingertips** 72:19

**finished** 20:8

**fire** 29:10 34:3,10,  
24 110:13

**firearm** 62:6,15  
73:9

**firearms** 23:25  
27:6,8,9 29:8  
30:10,12,16,20  
35:25 40:21 41:17  
47:10,13 49:13,  
17,18,24 50:2,9,  
12 53:14 73:2,8,  
19 74:13 83:8

123:6	110:5	fungi 99:14	10
<b>fired</b> 34:14 69:8 96:13 110:15,16, 19,22 111:4,16,20 112:8,12,15,24	<b>format</b> 56:20	<b>fuss</b> 61:12	<b>grammar</b> 80:23
<b>firing</b> 12:18 13:6 43:23 44:5,8,20, 23 46:5,9 47:25 48:3,9,10,18 54:2, 5,18,21 55:2,22 58:17 60:20 61:1 62:7,15,25 65:14 67:19 68:4,8,14, 19,25 69:13 71:14 72:11,14,17,25 74:2,3,6 77:5,9,18 78:12,16,20,21,22 79:9,19 80:12,25 82:2 84:2,9,13,18, 25 86:10,21,23 87:4,18 97:4 99:9 109:25 111:23 113:3 124:18,19, 20 125:1,2,5,6,9 126:2	<b>forms</b> 92:12		<b>grand</b> 23:3 55:7
	<b>formulate</b> 25:7	<b>G</b>	<b>Grant's</b> 18:20
	<b>fortunate</b> 31:1	<b>game</b> 93:4	<b>graphic</b> 126:5
	<b>fortunately</b> 25:16	<b>Gary</b> 41:22 82:21	<b>great</b> 33:23 53:8 64:12 102:18
	<b>forums</b> 42:6,19, 24	<b>gather</b> 40:25	<b>Grossman</b> 75:20, 23 76:21
	<b>forward</b> 105:19	<b>Gaussian</b> 56:20	<b>Grossman's</b> 18:7
	<b>found</b> 85:8	<b>gave</b> 12:5 18:7 59:21 105:6 123:3	<b>ground</b> 6:15
	<b>Fourteen</b> 121:13	<b>general</b> 12:24 21:16 40:4 47:11 82:7 83:11,14 92:5 114:6	<b>group</b> 29:25 54:12
	<b>fourth</b> 34:19 47:2	<b>General's</b> 4:4	<b>guarantee</b> 78:14
	<b>fourth-level</b> 30:1	<b>generally</b> 32:9 33:8	<b>guaranteed</b> 78:13
	<b>fracture</b> 94:17,23	<b>gentleman</b> 10:23 11:20 82:18	<b>guess</b> 8:15 39:24 41:12 48:6 79:17 96:7 99:17 119:24 120:19 122:14,17 123:2 130:6,8
	<b>fractures</b> 92:7 94:18 98:14	<b>gentlemen</b> 83:15	<b>guessing</b> 122:20
	<b>frame</b> 58:22 76:21 93:22	<b>genuinely</b> 107:1	<b>guideline</b> 28:5
	<b>France</b> 106:23	<b>Geodon</b> 131:4	<b>guidelines</b> 74:20
	<b>Francis</b> 23:3	<b>Georgia</b> 81:21	<b>guillotine</b> 106:24
	<b>frankly</b> 72:12	<b>geriatrics</b> 21:18	<b>gun</b> 34:10 53:10 96:13 102:2
	<b>free</b> 78:13	<b>give</b> 9:15 39:21 48:5 76:20 105:4 116:5 118:1	<b>Gunn</b> 5:7
	<b>Freeman</b> 13:10	<b>giving</b> 108:1	<b>gunshot</b> 12:18 16:5,19 25:14,16, 17,21 31:3 32:10 34:25 37:21 38:20 39:3,4,5,6,10,12, 22 40:22 41:24 47:13 55:22,23 56:3,9,17 57:11, 16,17,19,22 59:6 66:21 88:6,8,20 89:10 90:15,17, 19,22 91:16,24 92:1,3,5,6,7,9,15 94:13,25 95:4 98:16 99:1,4,9,18, 21 100:2,5,11 102:5 103:10,12, 14,16,17 104:2
	<b>frequent</b> 108:9,25	<b>glance</b> 36:12 37:4	
	<b>friends</b> 107:9	<b>Glossip</b> 45:10,22 117:21 118:8	
	<b>frightening</b> 76:6	<b>good</b> 4:2,17,22,23 16:23 19:21 32:16 69:1 84:11 120:24 122:4	
	<b>front</b> 6:1,3,9,10,13 8:6 35:14 45:24 98:4 99:24	<b>government</b> 83:3,13	
	<b>full</b> 35:5 49:21 76:10	<b>GPA</b> 19:23	
	<b>full-time</b> 21:13	<b>grades</b> 19:19,21	
	<b>fully</b> 25:11	<b>graduate</b> 19:22, 24	
	<b>function</b> 7:7 55:7 65:19,21 66:7,9, 15 87:9 88:12 106:14 109:5,13, 15	<b>graduated</b> 20:2,	
	<b>functional</b> 87:9		
	<b>functioning</b> 25:11 108:2		
<b>firm</b> 5:5 69:25			
<b>fixed</b> 63:1			
<b>flat</b> 63:11			
<b>flies</b> 47:19			
<b>Floyd</b> 11:3 17:24 45:12,13			
<b>Floyd's</b> 17:23			
<b>fluids</b> 58:10			
<b>focus</b> 29:2			
<b>follow</b> 32:15 56:12 74:20 87:11 107:16,20			
<b>football</b> 93:4			
<b>footnote</b> 123:11, 14,16 124:11			
<b>force</b> 24:3 31:10 65:20 75:7			
<b>Forces</b> 83:24 89:9			
<b>foremost</b> 11:4 16:18 83:7			
<b>form</b> 29:5 37:24 38:9 49:25 50:16			

105:13 119:7  
128:7,9,15,20,21  
**guys** 42:22,23

---

## H

---

**H-O-L-S-C-H-E-N**  
83:17

**habit** 11:22 12:2

**habits** 130:12,15,  
17

**Haldol** 131:1,2,4,  
7,8,16

**half** 47:23 60:10  
93:11

**handful** 33:22

**handgun** 29:23  
39:5

**handguns** 27:10  
29:20,22

**handled** 99:7

**hang** 49:1

**happen** 58:1  
125:19

**happened** 60:13  
110:14 117:11  
129:21

**hard** 32:2 35:19  
56:7 70:13 96:5

**hardness** 70:14

**hardwired** 76:4

**harm** 76:13,18

**He'll** 58:8

**head** 16:15 17:25  
31:23 32:1,5,10  
33:4 34:2,15,19  
35:1,8 37:3,17,20,  
22 38:7 63:18,20  
68:11 105:20  
107:2,6,8,10  
120:1

**head-to-toe**  
32:25

**Headquarters**  
127:12

**health** 130:10

**healthier** 129:16

**hear** 6:18

**heard** 58:23

**heart** 57:3 58:11  
64:12,19,22 65:1  
97:18,20 98:3,4  
102:2,5,9 103:12,  
17 109:14

**heavy** 70:1,2  
125:17

**heck** 33:4

**held** 27:19 83:6  
129:14

**helpful** 18:24

**hemodynamic**  
103:6

**hemodynamics**  
32:18 102:23

**high** 19:3,4,6,23  
29:7 52:15 90:14  
121:3

**high-power** 89:2

**high-powered**  
62:9 97:10

**higher** 73:21

**highlighted**  
46:19

**highly** 28:4 55:6,7  
75:22 88:23,24  
89:15,24 90:6,8  
91:8,9,17,20

**hinder** 13:20

**history** 12:13

**History's** 76:10

**hit** 34:15,18,19  
35:17,19,22  
36:15,19,21 38:7  
73:16,21 92:16,25  
93:2,3,8,13,14  
94:10 97:5,9,12,  
13 98:13 114:8  
125:7,10

**hits** 90:14 94:13,  
25

**hitting** 35:24  
37:22 87:20,21  
94:16

**hoc** 50:3

**Holsbine** 83:16

**Holschen** 82:20,  
21 83:17,18

**home** 5:15 97:2

**homicide** 76:2

**honest** 128:16

**hormone** 23:20

**hospital** 21:18,24  
22:4,25 23:2,3  
31:8 33:11 39:10  
57:24 96:19,23

**hospitalist** 21:19

**hospitals** 23:1,5,  
8 33:8 120:6  
121:7,10,11,14

**hour** 114:2,7

**hours** 58:9,13  
95:9 109:11

**house** 17:7

**Houston** 51:9

**huge** 35:7 91:10

**human** 30:25 37:3  
56:7,8 75:13 76:2,  
3,6,9,24 78:13,17

**humane** 114:11,  
12,14

**humans** 88:22

**hundred** 17:8  
38:16 119:3  
122:12

**hundreds** 9:21  
57:19 122:9,18  
128:7

**hunting** 28:13  
42:22,24 62:10,  
20,21

**hyperventilated**  
66:17

**hyperventilates**  
106:19

---

## I

---

**IALEFI** 46:24,25  
47:1,17 51:10

**ICUS** 109:3

**Idaho** 17:23

**idea** 38:11

**ideas** 71:21

**identification**  
64:3

**identify** 58:21  
62:17

**idiot** 129:14

**ILEETA** 47:2,3,7

**iliac** 105:7

**imagine** 51:23

**immediately**  
91:22 94:1  
112:11,13,15

**impact** 87:10  
91:3,4 97:11

**impaired** 102:24

**impervious** 69:4,  
12 70:3

**important** 69:21

**imported** 86:1

**imports** 40:23

**impossible** 70:18

**impression** 40:5  
56:11 94:7

**improbable**  
112:4,21

**improper** 116:23

**improperly**  
116:20 117:16  
118:13,22,25  
119:11,21,23,25  
120:8,11,15  
121:17 122:8,18

**impulses** 56:1  
107:25

**incapacitate**  
88:17

**incapacitation** 28:25 65:11,13,17

**inches** 59:4,12  
63:12 97:13

**incidence** 36:11  
69:10

**incident** 72:10

**include** 97:16  
104:6

**included** 91:8  
104:12,19,25  
105:5 130:17

**including** 9:11  
13:19 16:22 35:20

**income** 83:23

**incorporated** 24:13,19,20

**incorporation** 24:15,16

**independent** 23:7

**indifferent** 19:20

**individual** 31:9,  
12,14 32:13,25  
33:3,12 34:14,22,  
24 48:22 49:6  
66:17,25 71:24  
76:7,24 87:8  
102:1 106:18  
107:7 110:11  
111:25 112:12  
129:19

**individual's** 112:19

**individuals** 32:4,  
8 38:20 49:9 56:4,  
5 61:19 69:3 74:1  
76:13 77:8,17  
84:22,24 86:18  
89:14,17 93:7  
128:21

**induced** 131:14

**infarction** 57:4  
59:22 60:3

**infections** 99:21

**infectious** 57:5

**inferior** 64:21  
65:5 104:23

**infinitesimal** 55:17

**inflict** 76:9,13,18

**inflicting** 10:4  
66:24

**influence** 13:18

**influenced** 10:8,  
18

**information** 10:24 75:22 85:4

**informatively** 113:18

**informed** 89:14

**initial** 21:25 32:12

**initially** 93:16

**injection** 12:7,10,  
13 13:1,3,16 40:6  
61:11,24 113:8,  
19,23 114:10  
127:18

**injections** 23:21

**injure** 69:15

**injured** 39:9  
72:13

**injuries** 56:17,18  
57:4 59:23 69:22  
90:24 99:2 102:24  
103:5

**injury** 39:19 57:11  
70:11 87:7 88:11  
93:16,18,21 98:19  
123:6

**inmate** 68:8,14  
95:19,22

**innominate** 104:11 105:17

**inquiries** 83:10

**insert** 126:5

**insertion** 117:7

**inside** 33:4

**insipidus** 108:25

**instance** 46:24,25  
87:20

**instantaneous** 55:25

**instantaneously** 88:16

**instinctively** 76:3

**instinctly** 76:3

**institution** 19:14

**instructed** 30:8  
49:18

**instruction** 25:5

**instructor** 29:23,  
24 30:1,3,7,12  
49:19

**instructors** 30:9  
53:13

**instruments** 57:10

**intact** 32:16 35:4

**integrity** 103:6

**intensive** 12:20

**intention** 68:20,  
23

**intentional** 66:3

**intentionally** 123:7

**interdicted** 39:18

**interested** 20:25  
107:1

**interesting** 106:22

**intermittently** 40:13

**International** 30:4,7

**Internet** 41:13,15  
83:19 85:3

**interns** 5:3

**interpretations** 84:16

**interpreted** 84:7

**interrupt** 50:19

**intervene** 34:12

**intervening** 47:23 90:15

**interviewed** 89:8

**intoxicated** 35:6  
130:25 131:10,12,  
16,18

**intratracheal** 32:21

**intrinsic** 29:4

**introduce** 4:9

**introduced** 4:18

**introduction** 76:1

**intubation** 32:21

**involve** 72:5

**involved** 48:25  
55:18 61:13 86:18  
116:2

**involves** 55:8

**involving** 104:3

**Iraq** 83:25

**Island** 23:3

**issue** 41:24

**issued** 124:6  
132:5

**issues** 9:22,23  
13:14 18:8 33:1  
40:21,22,23 47:12

**IV** 116:21,22,25  
117:17 118:13  
121:25

---

**J**

---

**jail** 34:23

**James** 5:9 42:7,  
11,16

**January** 20:1  
82:14 118:2,8  
119:22 121:23  
122:17 127:14

**Jeremy** 5:6

**job** 22:6 23:11  
84:11

**John** 82:20,21  
83:17

**joke** 11:25

**Journal** 37:9

**journals** 37:12

**JSWMD** 42:8,11

**judge** 48:3 82:7  
83:11

**judgment** 35:4

**juice** 6:6

**Jules** 5:4

**July** 42:21 45:25  
129:5 130:22

**June** 45:25 47:21  
101:5

**jurisdictions**  
68:21,24

**Justice** 27:20  
30:13

---

## K

---

**Kevlar** 70:10  
71:22

**kids** 20:14

**kill** 62:16 86:8

**killer** 76:24

**killing** 18:8 75:21,  
24 76:5 87:1

**kind** 62:1,3 93:5  
112:25 116:23  
127:4

**kinds** 92:8

**King** 4:24 14:3

**Kingsville** 23:15

**knife** 92:4

**knocked** 125:24

**knowing** 108:2

**knowledge** 53:3,  
9 82:23 108:8  
110:14,17 111:5

**Kolodinsky**  
117:23

**Kur** 116:12

**Kursman** 5:2  
14:5,11,23 15:7  
117:23

---

## L

---

**lab** 33:7

**lack** 66:4 70:3  
105:25 120:13

**lapsed** 27:2

**large** 62:16 91:11

**Las** 45:10

**late** 16:17 42:24  
53:11 110:9 118:3

**lateral** 104:3

**law** 5:5 24:2  
40:23,24 41:17,19  
47:20,21 62:23  
73:7 76:13 78:8

**layman** 52:25  
93:17

**laymen** 52:22

**lead** 28:8 47:9

**leader** 110:12  
112:14

**leading** 75:25  
105:17

**leave** 132:6

**lectures** 46:13,16

**Ledford** 81:21

**Lee's** 15:24 16:25

**left** 46:16 63:13  
64:18 104:22  
105:15 122:24

**leg** 31:13

**length** 98:9

**Leonard** 4:23,24  
14:5,12 15:4,8,10

37:24 38:9 49:25  
50:16,24 110:5  
114:17,21 115:11  
116:12 132:11,19

**lethal** 12:7,10,13,  
25 13:3,16 40:6  
61:10,24 113:8,  
19,23 114:10  
127:17

**lethality** 39:2,12

**level** 29:7 68:20,  
23 69:1 72:5 76:5  
102:23

**library** 9:14,21  
10:1,2

**lies** 98:4

**Lieutenant** 18:7  
75:19,20,23

**life** 28:2 55:21  
65:20 91:22  
110:4,8,11  
111:12,15,19,23  
112:3,7,11,19,22  
114:11 123:12,24  
124:5,12

**lifelong** 11:22  
28:1,2 30:22

**likelihood** 69:16

**Likewise** 69:11

**limits** 86:25

**lines** 93:12 117:2,  
12 118:25 119:2,  
6,9,21,23,24  
120:25 121:8,12,  
19,20

**list** 8:6,7 18:6  
35:12 45:5 46:13  
57:6,8 59:21,22

**listed** 8:11

**literal** 86:4

**literature** 37:2,7,8  
52:2 53:22 59:9  
65:24 85:3 106:21  
108:8

**litigation** 8:14,23  
10:9 11:15 30:19  
43:7 46:6,7

101:14,18 115:25  
116:1

**live** 5:15

**lived** 16:20

**lives** 102:14

**LLC** 24:1,2

**load** 112:16

**lobby** 40:25

**local** 75:7

**located** 5:14  
69:13

**location** 117:8  
119:14

**locations** 8:17

**logs** 119:8,10  
120:5 121:9,15

**long** 21:9 24:11,  
24 26:7,15 42:15  
67:4 74:9 76:15,  
17 94:18 96:8  
106:10 107:1  
109:16 114:17  
129:14

**longer** 59:25  
66:19,20 85:5  
106:15,17,20

**longest** 107:11

**looked** 16:8,15  
18:7,10,13 33:23  
37:19 72:22 73:12  
74:16 77:22,25  
120:2,9

**lose** 107:18

**loss** 106:11,12  
107:16,24

**lost** 66:9

**lot** 12:9 39:16,17  
51:15 52:16,20  
99:20,21 104:14  
106:20 114:4  
117:2

**lots** 104:18 105:2  
107:18

**lousy** 130:11,15,  
16



**low** 35:12 70:21

**lower** 63:12

**lumbar** 70:1,8  
71:6

**lumen** 117:5

**lunch** 115:2

**lunchtime** 114:16

**lung** 90:21

**lungs** 65:6

**Lynne** 4:7,23  
14:5,11 50:20  
115:4,10 132:9

---

## M

---

**M.D.** 5:9

**M.sc.** 5:9

**made** 18:1 71:5  
115:11 125:4

**magnum** 96:18

**main** 56:16

**maintain** 26:12  
66:15

**maintaining**  
32:14 103:6

**Maio** 16:7,9,24  
18:3

**Maio's** 16:5 17:11

**major** 47:20 60:2  
62:8

**majority** 76:25

**make** 11:25 36:15,  
18,21 39:12 50:25  
59:1 101:7 117:13

**makes** 16:7 64:6  
76:5

**making** 21:24  
22:2

**male** 98:7

**males** 131:19

**mammal** 62:16

**man** 11:2 56:15

58:6,9,12

**manner** 44:6  
54:11,15 76:8  
131:13

**manual** 123:25  
124:1,7,12

**manufacturer**  
70:15

**March** 51:8

**margin** 64:21  
70:16 119:7

**mark** 101:21

**marked** 7:11  
43:12,14 100:13,  
17,21 101:9,23  
109:19,22 123:18,  
21 127:25 128:2  
131:25 132:1

**marksmanship**  
28:13 73:10 74:2,  
4,7,10,13 86:17

**martial** 94:5

**Martin** 16:16

**massive** 60:5

**master's** 20:3,8

**matches** 30:6

**material** 9:25  
24:15 70:1 81:3  
85:21

**materially** 85:22

**materials** 15:23  
69:4 70:9 79:7  
81:6 116:13,18  
132:5

**mathematics**  
20:16

**matter** 35:25  
66:11 76:12 86:4  
87:11

**maximum** 111:13

**MD** 20:17,24  
42:12,16 52:9,11

**meaningful**  
102:16

**meaningless**  
58:15

**means** 10:4 33:10  
43:23 54:2,17,21  
61:1,3 66:22  
69:21 78:23 82:3,  
11,13 83:22 85:1

**meant** 21:16  
87:15

**measure** 62:12  
122:16

**measured** 108:3  
125:12

**measures** 71:1,7,  
12,16

**mechanics** 61:8  
75:15

**mechanism**  
65:15,18 86:3

**media** 41:4,8,10,  
12 82:25

**mediastinum**  
64:13

**medic** 83:23,24  
91:18

**medical** 9:22 10:3  
13:22 20:9,11  
25:7,25 26:21  
30:21 37:8,12  
39:1 52:2,13  
59:25 60:17 64:9  
65:23 87:15 96:22  
102:19 108:8  
129:8,11,18,22  
130:14

**medication** 96:21  
103:7,9 131:9,15

**medications**  
13:19 103:2,7

**medicine** 20:10  
21:5,10,11,15  
22:23 26:6,8,23  
37:10

**medics** 89:9

**medium** 14:14

**Medline** 10:2

**meet** 4:5 73:6,20  
74:23

**meeting** 6:14  
47:4

**member** 25:11  
26:23 41:16,21  
42:1

**members** 25:6,8  
69:15 75:6

**membership**  
27:3 42:16 47:11

**memorized**  
107:23

**memory** 17:14  
120:9

**men** 23:20 128:9,  
11 129:10

**mention** 131:20

**mentioned** 57:16  
62:18 64:1 80:15  
83:15

**message** 41:13,  
15,18

**met** 73:10

**metastasis** 58:7,  
12 59:12

**method** 78:24  
88:5,18 114:11

**methods** 44:16

**Metro** 39:2 74:21  
75:2,5

**Miami** 39:1,2

**mid-1800s** 72:12,  
18

**mid-20s** 72:23

**middle** 39:15 89:7

**might've** 15:12

**military** 40:23  
76:23 78:24 79:2  
81:23 83:13  
84:12,18,21 85:1  
113:2 127:9,17,  
20,22

**millimeters** 98:7

**milliseconds**

87:10

**mind** 11:4 13:10  
18:11

**mine** 129:2

**minimize** 11:6

**minimum** 73:6  
74:12

**minor** 23:21 39:19  
81:10 105:12

**minority** 39:11,23

**minute** 110:20  
111:22 112:6

**minutes** 59:11  
67:2 94:22 107:14  
110:3,10,12  
111:13,18,25  
112:3,6,8,23  
114:19 115:9

**misconception**  
99:6

**missed** 47:1

**misstated** 101:19

**mistaken** 48:25  
49:7 128:24

**Mitchell** 4:2,3,6,  
11,13,17,18 5:13  
7:7,9,13 11:21  
38:5,11,13 43:12,  
16 50:7,18,22  
51:2,3 53:2,7  
67:12 100:13,16,  
19,23 101:7,11,  
21,25 109:18,24  
110:21 114:15,19,  
22,25 115:4,7  
116:3,24 117:3  
119:17 120:11  
121:4,6 122:14,22  
123:18,23 124:23,  
24 128:4 131:24  
132:3,8,9,15,16

**mixed** 26:18  
115:17

**mixing** 68:10

**moment** 66:18  
108:7 123:25

**month** 45:13 46:4  
72:22

**months** 15:1 58:6  
59:4 76:22

**morning** 4:2,17,  
22,23 45:20 96:24

**mortality** 65:15  
66:24

**motor** 57:5 59:22  
60:6,12,13

**moved** 17:7

**movement** 91:21

**moves** 94:23

**moving** 63:2  
112:13

**multiple** 75:4  
91:7 124:6

**myocardia** 59:22  
60:3

**myocardial** 57:3

---

## N

---

**naked** 130:25  
131:10,17,18

**names** 11:4,22  
12:4 23:17 37:16,  
18

**narcotic** 103:7

**narcotics** 96:21

**Nashville** 5:5  
74:21 75:2,5

**National** 27:15  
29:24

**nature** 5:24 37:9  
55:9 69:17 96:8

**Navy** 83:5

**Nebraska** 23:4

**necessarily** 11:1  
12:14 47:5 88:8  
107:16

**neck** 34:19 105:19

**negate** 93:21

**negatives** 78:15

**negligible** 86:19

**neighborhood**  
51:15

**nerve** 88:14 97:14

**nerves** 56:13  
97:15,16

**nervous** 65:19

**neural** 55:9  
107:24

**neurological**  
55:13 56:1

**neurons** 66:7

**neurosurgeon**  
33:16

**neurosurgery**  
33:17,19,22,24

**neurosurgical**  
33:9,11,20

**neurotoxins**  
23:22

**Nevada** 10:23  
11:2,7,15 12:6,22  
13:8,17 17:18  
45:11 48:4 49:21  
50:17 51:7 115:16

**news** 42:22

**Nice** 4:5

**night** 14:7,14

**nil** 68:22 70:20

**Nonetheless**  
12:5

**nonlethal** 39:17

**nonresponsive**  
119:18 121:5

**notepad** 6:6

**Notice** 7:20

**Notwithstanding**  
91:1

**November** 17:18  
43:9 45:5,14,15,  
21 53:11 54:25  
60:23 72:23

**noxious** 55:9

**NRA** 28:5

**number** 7:12  
16:21 39:21 41:17  
43:15 57:25 72:19  
75:6 77:12 83:25  
85:20 100:22  
101:10,24 102:6  
109:23 116:7  
123:22 128:3  
130:5 132:2

**numbers** 120:2

**nursing** 121:2

---

## O

---

**object** 37:24 38:9  
49:25 50:16 93:2  
110:5 119:17  
121:4

**objection** 50:23

**objective** 28:23

**observation**  
96:24

**observe** 58:25

**observer** 33:21

**observing** 5:3

**obstetrics** 21:17

**obtain** 19:14 33:7  
125:22

**obtained** 19:8,23  
86:24 126:17

**obvious** 97:9  
112:10

**occasion** 22:17

**occasions** 75:3

**occupation** 21:7

**occupations**  
23:13,23

**occur** 25:12 61:25  
90:24 94:8

**occurrence**  
117:10

**occurring** 71:2



**occurs** 59:11  
62:25

**ocean** 55:17

**October** 49:18  
50:8

**offer** 51:19

**offered** 49:19

**office** 4:4 5:2  
126:21

**officer** 30:7 31:9,  
11 73:25

**officer-involved**  
29:15

**officers** 28:23  
34:10,12,14,25  
40:23 73:13 77:20

**Ohio** 126:18,20,  
22,23

**Oklahoma**  
117:21

**older** 78:20 80:12,  
20,25

**oldest** 128:14

**omitted** 71:10

**on-the-spot** 50:5

**one-year** 19:19

**onerous** 61:10

**online** 10:2 16:8

**open** 6:13 132:6

**opens** 99:11

**operated** 24:11

**operating** 29:7  
57:23 97:1

**operation** 25:13  
30:10 99:16

**operations**  
25:10,19

**operator** 113:19,  
23 125:21

**opine** 113:18,22

**opinion** 12:23,24  
38:4,6 59:8 64:6  
85:12 86:22,23

87:12,18 88:5  
114:6 129:14,18,  
19 130:14

**opportunity**  
118:16 119:4  
122:24

**opposed** 22:18  
93:24

**orange** 6:6

**order** 76:8,13

**orders** 132:12,14

**organization**  
48:9 52:6 75:6  
83:6

**organized** 107:24

**organizing** 30:6

**outcome** 29:15

**outcomes** 35:8

**overestimate**  
123:3

**overkill** 86:4

**overlapping**  
63:13

**overnight** 96:23

**oversight** 25:12

**oversimplify**  
93:19

**oxygen** 66:5,6,8,  
10,14,15,23

---

## P

---

**p.m.** 115:3 132:23

**pages** 41:25

**pain** 55:6,14,17,20  
56:1,4 92:8 93:14,  
16 94:21,22,24  
95:9,11,15 97:16  
98:21 102:9,10,11  
103:2,6,7,8 130:6,  
7,9

**painful** 56:15,23  
57:13,17 58:6  
91:25 92:2,5,6,7,  
10,11,13 93:20,24

94:1,8,11,13,15,  
16,17,18 95:1,6  
98:1,12,15,17,20

**painless** 44:6  
54:16 55:3,5,12,  
17,19,22 56:14  
60:20 87:5,19  
88:5,19

**panel** 47:7,8,10

**panic** 96:7

**paper** 8:15 16:22  
17:5 63:10

**papers** 9:22 16:8,  
9,12,16,21 17:2,8,  
10

**paragraph** 91:14,  
19 130:3

**parameter**  
131:23

**part** 12:2 46:2  
63:13,15 71:19  
75:8 90:21 94:16,  
17 104:15 105:9

**part-time** 21:12  
23:1 83:21

**participant** 48:18

**participate** 47:5

**particles** 99:14

**pass** 29:9 36:8  
70:6,12 91:2

**passes** 90:11  
99:10

**passing** 55:21

**past** 14:12 36:9  
41:1,11,17 49:13  
51:25 75:3

**patient** 11:24 12:2  
33:10 117:14  
118:13 121:18  
122:19

**patients** 22:12  
98:20 121:21

**Patrol** 75:5

**pattern** 56:13

**pause** 67:1

**PD** 75:2,5

**PDF** 132:16

**peace** 73:13,25

**Pecos** 23:2

**pediatric** 128:24

**pediatrics** 21:18

**penalty** 9:22  
126:17

**penetrate** 36:5,12  
69:9 70:4

**penetrates** 90:10,  
19

**penetrating** 37:5  
90:16

**Pentagon** 83:10

**people** 14:6  
22:10,20 29:5,6  
30:9 31:25 38:14,  
23 39:7,8,9,22  
52:20 57:4,21  
58:20,24 59:3,17  
62:17 76:10,25  
77:12 86:23  
91:18,20 92:19,  
21,22 93:5,16,21  
94:3,4,21 102:8,  
13,17,18,22  
103:2,4,25 104:1,  
4 107:18 114:5  
128:16,17 131:12

**perceive** 93:16

**percent** 32:7  
37:23 38:3,7 39:4,  
24 65:9 70:20  
118:24 119:20,23,  
24 120:3,20,23  
121:19,25 122:10  
123:8 130:7

**percentage**  
38:12 120:22

**perfecting** 12:2

**perform** 22:9,11,  
20 25:21,23 33:17  
51:5

**performed** 33:19,  
24 114:9,13

**period** 42:1 94:20  
106:19 120:7

**peripheral** 34:16  
121:18,19,20,25  
122:8,19

**periphery** 90:10

**perpendicular**  
36:7,25

**person** 54:8,10  
55:20 56:10,11  
60:11 61:4 62:2  
63:20 69:24 72:2  
73:23 76:14,18,19  
77:1 82:24 87:2  
89:1 90:7 93:14  
109:3,13,15  
128:14,19

**personal** 41:5  
83:20 90:15

**personally** 49:8  
58:22 59:15 77:8  
95:3

**personnel** 24:3  
54:9 75:8 78:9  
89:8

**perspective**  
102:19

**pharmacokinetic  
s** 13:15

**pharmacology**  
13:14

**phenothiazine**  
131:8

**Philadelphia** 5:2

**phobia** 76:2

**phobic** 76:6

**phone** 6:7 14:14,  
16

**phonetic** 29:25

**photographic**  
18:22

**physical** 115:23

**physician** 11:23  
21:8,14,21,23  
23:11 24:22 25:2,  
4,14,17 56:22

57:14 60:15  
106:22 111:13  
112:7 121:1 128:6

**physicians**  
26:14,16 65:24

**physics** 20:15

**physiology**  
87:15,16

**picture** 29:5  
125:22

**piece** 63:11 88:9

**pistol** 27:10  
29:10,24 30:2,5,6,  
8,13 37:3 96:14,  
15,16

**Pizzuto** 17:22

**place** 22:24 28:4,  
24 51:18 54:9  
61:4 97:9 117:7  
118:22,25 121:17  
122:19 129:16

**placement** 22:13  
28:22 120:22  
121:8

**placing** 63:23  
64:2 69:3 120:24

**plaintiff** 4:24

**plaintiff's** 11:14  
44:12,19 113:22  
115:10 132:20

**plaintiffs** 68:10

**plan** 127:1

**platform** 69:25  
71:23

**play** 11:1

**PLLC** 23:18

**plywood** 70:7,8

**pocket** 18:23

**poignant** 40:25

**point** 16:24 23:6  
28:10 95:8

**pointed** 115:11

**points** 12:8 14:18  
17:19 18:1 81:11,

13 84:5

**police** 28:21 31:9  
40:22 62:10 73:19  
75:7

**policies** 25:7

**pop** 130:20

**population**  
129:15

**portion** 36:8  
39:15 52:18

**portions** 17:14  
63:8

**position** 63:1  
68:3,7 79:25  
129:23

**possess** 126:11

**possession** 10:1,  
7

**possibility** 68:22  
69:14 70:19 71:8,  
13 88:4 91:2 92:1  
111:21 112:20  
113:1

**possibly** 75:24  
122:15

**post** 74:20 129:1  
130:18,21,22  
131:20

**posterior** 63:14

**postinjury** 94:20

**postmortem** 64:3

**potential** 35:7,10  
90:22

**practicable** 33:2

**practical** 81:11  
84:2,3

**practicality** 12:15  
84:6

**practice** 21:12,16  
22:23,24 23:1,5

**practiced** 21:9,14

**practicing** 21:11

**preceded** 80:21

**precedent** 21:14

**precipitate** 109:1

**precise** 36:10

**precisely** 28:24  
36:6 91:14

**precision** 32:6

**preclude** 126:23

**predictable**  
91:17,21

**preferable** 58:14  
62:18 86:16,20

**preliminaries** 4:6

**preparation** 9:17  
10:20 14:21  
15:17,24 17:17  
115:13,15,16,18

**prepare** 13:25  
15:14,19 43:1  
80:10

**prepared** 10:18  
81:25 115:4  
122:21

**preparing** 8:8  
16:24 17:20,22  
20:4 80:1 113:7

**prescribed** 56:13  
74:14

**present** 22:1  
31:2,19,22 33:20  
41:17 47:5 48:20  
53:13 60:6,12,15  
110:4 111:15,19  
112:7,23

**presentation**  
36:25 39:16 63:14  
64:15 91:6 98:11

**presented** 46:14  
47:17,20,22

**presenter** 47:14,  
16

**pretty** 21:20  
30:17,20 39:9  
71:9 88:25  
117:10,13

**prevent** 71:1

**preventing** 69:22

**previous** 81:5  
100:10

**previously** 25:23

**primarily** 14:16,  
17 16:4 18:2  
22:18 24:2 25:5  
27:10

**primary** 21:7  
22:24 23:11 35:12  
41:23 42:9 65:7,  
15 81:1 83:22  
103:5

**primaryandseco  
ndary.com** 41:20

**principles** 25:9

**printed** 6:11

**prior** 10:25 14:24  
24:16 66:17  
106:19,25

**prison** 49:3

**private** 21:12

**privileges** 23:4

**probability** 70:21  
112:2

**problem** 120:18

**problems** 12:7  
119:13

**procedural** 22:18

**procedure** 81:10,  
13 119:8,10  
120:5,13,15,17  
121:9,15

**procedures**  
22:11,14 23:21  
33:21 120:6  
127:9,20,22

**proceed** 33:6  
106:3 115:5

**proceeded** 19:24

**proceedings**  
132:23

**process** 55:21  
112:4

**processes** 84:8

**produce** 7:23,25  
8:4,10,13,19,22  
29:14 39:18 56:19  
65:10 87:6 89:3  
99:1

**produced** 8:2

**professional**  
26:19 27:4 48:7,9  
89:20 129:22

**professionally**  
21:6 129:25

**proficiency** 29:8  
73:2,19,24

**program** 19:21,24  
20:2

**progresses**  
93:18

**progression**  
93:15

**projectile** 62:15

**projectiles** 53:18  
54:11 86:6

**proper** 125:22

**proposed** 13:16

**prostate** 58:7

**protect** 97:18,20  
98:3

**protection** 69:2

**protocol** 44:20,22  
63:19 70:24  
78:20,21,25 79:1,  
3,8,19,21 80:4,7,  
11,13,15,21,25  
81:1,2,4,6,14,17,  
23 82:1 84:1,2,4,  
10,16 85:6,9,13,  
18 86:9,14 95:20,  
23 100:17 101:2,  
12 110:1,2,7,10  
111:10,24 112:5  
113:8,11,13,19,24  
124:18,19,20,25  
125:1,2,5

**protocol's** 84:7

**protocols** 79:5  
80:1,19,24 84:6

101:17

**provide** 9:4,7  
10:8 25:5,12 69:1  
81:5 106:4 126:8

**provided** 8:7  
10:11 16:22 36:5  
50:3 81:19 100:3  
124:3 126:10

**provider** 50:2

**psychological**  
76:4

**psychologically**  
77:1

**psychology**  
75:18,24

**psychosis** 131:9,  
13,14

**psychotic** 131:8

**publication** 52:7  
75:21

**publications**  
51:24

**published** 52:2,  
10,12 53:22 80:7

**pull** 34:10

**pulmonary** 58:10  
63:16 65:2,3,6  
104:21,22 108:9,  
11,24 109:6,10,16

**punched** 93:3

**purpose** 63:23  
64:2

**purposeful** 91:21

**purposes** 23:22  
62:23

**pursue** 19:12,16

**pursued** 19:13  
20:24

**put** 63:20 72:3  
78:14 82:17 92:2  
93:5 104:2 105:7  
119:12

---

**Q**

---

**quadrant** 91:12

**quadruple** 86:3

**qualification**  
27:20 28:5 29:9  
73:8,20

**qualifications**  
29:23

**qualified** 10:13  
28:4,6

**qualify** 30:3  
73:14,15

**quantified** 59:9

**quantities** 55:16

**quasi** 22:16

**quasi-surgical**  
22:13

**question** 7:2  
44:5,8 50:24  
58:15 68:5 99:23  
118:10 120:1  
122:21 124:22

**questions** 5:13  
35:5 43:20,25  
44:2,4,13,15  
47:10 132:4

**quick** 44:6 54:15  
55:3 58:3,8,14,18,  
19 59:2,7,10,16,  
24 60:5,20 87:5,  
19 100:20

**quickest** 114:10

**quickly** 59:17  
131:5

**quickness** 58:15

**quote** 49:12

---

**R**

---

**rain** 125:9

**rainfall** 125:11,17

**rainstorms**  
125:19

**raised** 13:1 107:6  
**random** 37:21  
 38:7  
**range** 73:17  
**rapid** 131:6  
**rapidly** 109:12  
 110:20  
**rare** 55:10,11,12,  
 14 117:10  
**rarely** 41:21 42:1,  
 2  
**rate** 121:3  
**rates** 119:6  
**raw** 76:23  
**reaching** 90:12  
**read** 9:21 10:6  
 12:6 15:16 17:8,  
 10,12,13 37:9  
 42:3 58:23 64:1,4,  
 5 75:22 118:10,18  
 125:4 130:3  
**reading** 12:9  
 15:18 84:10  
 118:12,22 130:5,  
 24  
**real** 12:4 53:18  
 84:13 100:20  
 117:14  
**realized** 119:5  
**realm** 88:4 94:3  
**realms** 112:25  
**rearrange** 117:1  
**reasonable** 73:18  
 82:15  
**reasons** 35:10  
 99:22  
**reassess** 32:18  
**rebar** 88:9  
**recall** 11:13 12:4  
 15:18 18:21 19:2  
 26:25 42:8,12,15,  
 17 48:24 81:8  
 82:22 96:6 102:10  
 103:15,17 118:3,  
 7,15,18 120:14

123:11 126:20,25  
 127:2,3  
**receive** 96:22  
 126:15  
**received** 10:15  
 19:10,11 31:3  
 34:2 52:9 95:3  
 96:21 112:1  
 128:9,15,20 132:4  
**receiving** 34:3,25  
 93:25 94:7  
**recent** 75:9  
 101:16  
**recently** 17:7  
 49:2 74:17  
**receptors** 97:16  
**recess** 67:10  
**recognize** 7:14  
 43:5 100:24  
**recollection** 80:8  
 117:19 120:19  
 122:25 126:16  
**recommend**  
 75:23 131:2  
**record** 4:9  
 107:11,12 115:6  
 132:13,14  
**records** 9:5 40:4  
 51:20,22 75:11  
 121:8 123:1  
**recruit** 76:23  
**reduce** 125:17  
**Reeves** 23:2  
**refer** 52:21 79:4  
 80:20 90:1,2  
 91:12  
**reference** 58:23  
**referenced** 16:9  
 123:25 124:2  
**references** 16:7  
 18:6  
**referred** 45:11  
 62:9 104:21  
**referring** 80:22  
 109:2

**refine** 29:13  
**refiring** 110:18  
**refresh** 17:14  
**refreshers** 18:11  
**region** 91:14  
 98:21  
**regular** 73:15  
 119:8  
**rehearsed** 62:4  
**Reign** 106:23  
**related** 9:23 12:7  
 25:21 47:25 52:12  
 67:19,21  
**relating** 10:3  
 48:10  
**relative** 59:13  
**relevant** 17:14  
 67:16,18 105:13  
**reliability** 12:25  
**reliable** 38:25  
**relied** 9:8 18:19  
 30:18 81:16  
 101:3,13,17 110:1  
**rely** 9:11,13,18  
 10:17 16:24  
 87:12,14,20  
 127:22  
**relying** 81:25  
**remaining** 70:11  
**remember** 11:12,  
 23 46:4  
**remembering**  
 11:22  
**remind** 116:13  
**remote** 69:13  
**removed** 97:2  
 129:15  
**render** 60:17  
**repeat** 6:17 68:5  
 124:21  
**rephrase** 50:25  
 111:2

**replace** 117:1  
**replacement**  
 23:20  
**report** 6:8,10 8:8  
 9:9,17,18 14:20  
 15:10,25 17:17,  
 20,22,23 30:19  
 43:1,7,22 44:25  
 49:11 54:1 78:19  
 79:7,11,20,23  
 80:1,11 81:7,16,  
 19 89:5 94:21,22  
 101:3,14,17 110:2  
 111:6 113:7 116:6  
 123:5 124:15  
 125:3 126:4  
**reported** 58:25  
 72:10  
**Reporter** 4:7,8,12  
 100:15,18 109:21  
 123:20 124:21  
 132:12,18,21  
**reports** 15:21  
 37:13,16 45:6  
 72:13 81:22,25  
**represent** 4:24  
 117:24  
**request** 11:8  
**requests** 121:2  
**require** 66:8  
 85:13,18  
**required** 22:2  
 61:10 73:21 111:1  
 112:17,20 117:3  
 119:14  
**requirement**  
 74:12,15,16  
**requirements**  
 73:10,13 74:11,  
 21,23  
**requires** 36:6  
 63:19 85:14  
**requisite** 74:1  
**reread** 17:19  
**research** 52:6  
 119:12  
**reserve** 66:18

83:6  
**reserves** 66:15  
**residency** 20:21  
21:4  
**resident** 120:14  
**resistant** 69:3,5,6  
**respect** 15:22  
89:10  
**respiratory** 57:6  
**responding**  
102:15  
**response** 16:2  
88:22,25 89:14,23  
90:8 91:21,23  
96:6  
**responsibilities**  
21:22 22:7  
**responsibility**  
21:24  
**responsive** 132:5  
**rest** 28:22 108:1  
**result** 54:15 55:3,  
25 56:10 58:18  
60:20 87:4,19  
93:14 94:17  
**resulted** 39:5  
**resulting** 57:6  
**results** 66:2  
**resumed** 67:11  
115:3  
**retained** 126:18  
**return** 34:3,24  
65:3  
**returned** 19:18  
**returning** 54:1  
65:6  
**review** 15:19  
16:22 17:2,18,25  
18:4,25 51:14  
81:2 86:12 110:6  
113:7,16 115:14  
116:18 119:4,10  
121:7,9,15 122:24  
125:2

**reviewed** 9:16  
15:21,22,23,24,25  
16:21 17:23  
18:14,18,21 45:3  
69:19 80:11,23  
113:10 115:13,21  
116:7,13  
**reviewing** 35:14  
**revolver** 53:10  
**rib** 90:11 97:11,13  
**ribcage** 97:18,20,  
21 98:23 103:20  
**ribs** 97:21,22,25  
104:1,3  
**ricochet** 68:18  
69:14,23 70:19  
71:2 72:10,13  
**ricochetting**  
71:8,13  
**rifle** 27:15,20,23  
28:1,3,16 29:2,3,  
10,14,17,24 39:25  
62:10,16,20,22  
73:7,14,20,24,25  
78:10 86:2 88:23  
89:1,2,15,23 90:6  
112:1 125:21  
**rifle's** 125:23  
**riflemen** 54:12  
61:7 63:3 73:4  
85:13,16,17 86:5  
87:20,23  
**riflery** 27:25 28:9  
**rifles** 27:11 28:12,  
21 54:15 61:6  
62:8 69:9 87:6  
97:10 112:16  
123:7  
**rigorous** 74:19  
**rimfire** 36:4 96:18  
**risk** 68:18,21  
113:18,23  
**Road** 5:17  
**Rob** 4:3,18 53:2  
**Roberts** 41:22  
82:22 83:4,7

**Roberts'** 83:2  
**rock** 93:3  
**Rocket** 42:5,17  
129:1  
**role** 83:2,12  
**room** 5:19 21:19  
31:8 34:2,22 39:8  
57:23  
**root** 65:2 104:9  
**roots** 63:16  
104:10  
**roughly** 64:16,21  
**round** 67:6 88:1  
126:2  
**rounds** 112:16,17  
**roundtable** 47:12  
**row** 10:23  
**rules** 6:15  
**running** 39:15  
86:23

---

## S

---

**SADAA** 29:25  
**safe** 29:5 30:9  
**safety** 30:7  
**Saint** 23:3  
**SAITH** 132:22  
**sandbags** 70:9  
**satisfaction**  
120:21  
**scalp** 34:18 36:13  
**scanner** 33:3  
**scene** 60:6 61:23  
**scheme** 55:8  
**school** 19:3,4,5,6,  
15,17,22 20:9,10,  
12  
**scientific** 112:25  
**Scott** 4:20  
**screen** 7:7,15  
11:6 43:4  
**scroll** 79:13  
100:25  
**search** 39:20 78:3  
**searches** 10:2  
85:3  
**Secondary** 41:23  
42:9  
**seconds** 59:5  
66:11,17,19 87:11  
91:23 93:20 94:8,  
20,22 106:13  
107:10  
**section** 91:13  
112:9  
**secure** 32:20  
**seek** 16:13  
**segment** 91:13  
**sensation** 55:9  
93:23,25  
**sensations** 55:9  
**sense** 22:10 64:6  
96:6  
**sentence** 89:7,13  
91:13,19 100:5  
123:5  
**sentences** 89:25  
**separate** 103:14  
**September** 20:2  
**series** 59:6  
**serve** 74:2  
**served** 24:21  
27:22 40:8 47:7  
83:23 89:9 117:20  
**services** 21:23  
22:17 23:10  
**set** 91:5  
**setting** 109:8  
**settings** 109:9  
**settling** 22:3  
**seventies** 128:18  
**severe** 34:16  
125:19

**severed** 107:8,10  
**severing** 107:2  
**sex** 130:7  
**share** 7:7,15 43:4  
**sharpshooter** 28:5  
**sheriff** 34:11  
**sheriff's** 25:7 27:21 28:6 34:10, 12 75:7  
**shocking** 96:2  
**shoot** 54:14 77:1 90:7  
**shooter** 28:2 74:3,6  
**shooter's** 125:6, 9,14  
**shooters** 126:1  
**shooting** 29:15 75:13,14  
**short** 9:19 36:17 55:23 125:18  
**shortest** 21:4 28:25  
**shortly** 61:21  
**shot** 28:22 30:25 31:9,12,19,22,25 35:8 38:7,15 39:7 61:5 63:20 65:9 88:23 89:15,23 90:1,2,6 92:21,22 93:7 95:6,14,16, 17,25 96:2,9,11, 17 102:2,5,9 103:19 104:1 109:14 123:7  
**shotgun** 29:10  
**shots** 28:24  
**shoulder** 95:17, 19,22  
**show** 7:6,10 11:9 123:6 128:25  
**showing** 10:12  
**shows** 110:11 112:10

**shutdown** 109:12  
**sick** 102:11  
**side** 72:4 76:12 90:11,20,21 97:22 104:22 117:8 132:20  
**sides** 71:22,24  
**sign** 108:6 112:22  
**signature** 43:17  
**significant** 32:19  
**significantly** 120:3  
**signs** 91:22 110:3,8,11 111:12,15,19,23 112:3,6,10  
**similar** 56:17 88:25  
**Similarly** 125:20  
**similes** 93:5  
**simply** 29:13  
**Sims** 5:5  
**simultaneously** 20:4  
**single** 86:1 120:14  
**sinus** 65:4 104:23,24  
**sir** 5:22 7:24 18:16 19:17 20:20 22:8 35:19 43:10 49:10 50:13 55:6 58:15 59:13 63:21 67:1, 9,22 68:11 70:25 79:24 81:15 87:14 92:14 98:25 101:4 104:7 108:22  
**sit** 127:2  
**site** 53:11 125:22, 23  
**siting** 125:20  
**situation** 13:12 34:13 61:20 109:3 129:25

**skeptical** 13:2  
**skill** 29:13  
**skin** 34:17 88:15 90:9 99:10,11,12  
**skull** 35:23 36:1,8, 24 37:4,5  
**skull's** 36:18  
**skull-related** 37:11  
**slight** 68:22  
**slits** 69:13  
**slots** 69:15  
**slow** 58:13  
**slowly** 58:9  
**slows** 70:2  
**small** 21:4 35:11, 18,19 39:11,24 58:1 69:13,16 89:4 125:8  
**social** 41:4,8,10, 12  
**sole** 59:25 60:2 116:14  
**solution** 131:1  
**sort** 12:19 13:8 48:7 56:9 61:9 71:18 72:21,24 82:25 91:16  
**sought** 129:8  
**source** 18:21  
**sources** 8:7 10:5 18:13,14 38:25 64:1 81:2  
**space** 28:22  
**speak** 13:25 14:22 15:13 28:14 35:5 55:19 67:23 82:24 84:14 107:3 115:9 116:16  
**speaker** 46:20  
**speaking** 33:8 55:19 116:10  
**specialist** 12:20

**specialize** 23:19  
**specialized** 20:14  
**specific** 16:15 44:4 73:16,17 76:21 84:4,5  
**specifically** 13:14 77:11,15 93:10 113:21 115:24 116:24 118:15,18 124:2  
**spectrum** 55:20  
**spelling** 83:18  
**spending** 130:10  
**spinal** 99:2  
**spine** 91:4 97:11 98:16,19  
**spoke** 14:2,5,24 15:1 67:24 82:18 115:10 119:15  
**spoken** 14:25 48:18,20 49:8 77:4 91:18  
**sports** 26:23 94:5  
**squad** 12:18 13:6 43:23 44:6,9,20, 23 46:6,9 48:1,3, 9,19 54:2,5,18,21 55:2,22 58:17 60:20 61:1 62:7, 25 65:14 67:19 68:4,9,14,19,25 69:2,11,15 71:14 72:11,14,17,25 74:2,3,6 77:6,10, 18 78:12,16,20, 21,22 79:9,19 80:12,25 82:2 84:2,9,13,18,25 86:10,13,21 87:4, 19 97:5 110:1,13 112:14 113:3 124:18,19,20 125:1,2,5,6,9 126:2  
**squads** 48:11 86:23  
**stability** 32:17



**stable** 32:18

**staff** 121:2

**standard** 32:15  
73:6,18,19,21  
114:8

**standards** 74:19

**start** 94:21

**started** 4:10  
19:25 130:25

**starting** 16:23

**state** 27:21 30:5  
40:8 48:3,4 49:12,  
21 54:9,13 63:21  
73:7,9,11 74:23,  
24,25 75:5 77:21,  
25 78:1,6 80:22  
89:8 126:18

**state's** 74:11

**stated** 111:12  
129:14

**statement** 85:12  
120:19 123:10  
124:15

**statements** 90:5

**states** 74:12  
76:23 83:5,24  
84:12,21 127:17

**stationary** 63:1

**statistic** 38:4  
77:24

**stay** 66:8 87:1

**stem** 35:11,17,20,  
22,24 36:16,19,  
21,22 37:22 38:8  
55:24 88:6,11,12,  
20

**step** 32:23

**steps** 61:8 72:7

**sterilized** 99:9

**sternal** 98:14  
103:15

**sternum** 63:13  
64:17 97:8 98:3,6,  
13,24 103:11,14

**sternum's** 98:5,9

**Steven** 116:8

**stimulus** 76:6

**stop** 66:13,14  
91:21 101:1

**stopped** 82:17  
127:4

**stopping** 66:23

**storage** 17:8

**strapped** 69:24

**striking** 37:3

**stroke** 60:5

**strong** 40:25

**struck** 91:20  
93:19

**structure** 91:10  
97:19

**structures** 39:17  
64:14,23 90:4  
104:24 105:12

**student** 19:20

**students** 123:13

**studied** 53:8 83:9

**studies** 19:19  
20:5

**study** 20:23 30:22  
39:2 53:2

**studying** 9:24

**stuff** 51:16 67:20  
80:5

**stunned** 96:3

**stunning** 93:23  
94:1

**subclavian**  
104:17 105:7  
117:5,9 120:16

**subject** 69:23

**subjective** 55:6,7  
56:11 58:5,16,18,  
20 59:7 75:16  
94:24

**submission** 45:4

**submitted** 14:19  
15:25 45:1

**submitting** 9:18  
15:9

**subpoena** 7:20  
8:11 15:22 132:5

**subsequent**  
111:23

**subsequently**  
11:16 113:10

**substantial** 70:16

**substantially**  
13:4

**success** 121:3

**successful**  
120:21

**successfully**  
76:11 87:1

**sufficient** 62:15,  
24 66:9 70:13  
86:2,7 112:19

**sufficiently** 10:13

**suffocating** 58:9

**suffocation**  
58:13

**suggest** 84:15  
85:4 111:25

**suggesting** 85:6

**suggests** 76:21  
85:9

**suite** 97:1

**sum** 18:12 36:17  
50:6 51:11

**summarizing**  
111:9

**summer** 42:21

**superficial** 34:20,  
21

**superior** 65:5  
104:23

**superiorly**  
105:17 106:3

**supplied** 75:21  
108:14,19 126:1

**supply** 66:8 81:6  
105:20 106:10

**support** 78:21  
106:21 123:12,25  
124:6,12

**supporting** 16:2,  
3

**suppose** 8:17  
71:25 94:12 97:12

**surface** 36:18

**surfaces** 70:13

**surfeit** 129:7

**surg** 22:16

**Surgeons** 123:12

**surgery** 21:17  
22:9,10,11,21  
25:21,23

**surgical** 22:19

**surround** 71:24

**survey** 32:24

**survivable** 39:19

**survive** 104:4

**survived** 34:22  
103:25 104:1

**sustained** 39:4  
59:23 102:25  
103:5

**Sutherland** 4:21

**SWAT** 24:21,25  
25:2,4,8,10,11,13,  
14

**swear** 4:14

**switching** 123:4

**sword** 92:3

**sworn** 5:10 77:20

**sympathy** 63:24

**symposium**  
53:10

**symptoms** 91:5

**system** 65:19  
66:23 91:11 127:9  
130:10

**systems** 24:1,4,7,  
12 40:16 41:7  
50:12,15 51:5,17  
125:20

---

**T**

---

**T3c** 25:9

**tackled** 93:4

**tactical** 24:1,4,6,  
11,13,17,19 25:9  
28:13,15,20 40:16  
41:6 49:20,21  
50:11,14 51:5,17,  
19

**tag** 12:1

**takes** 59:5 66:10  
71:1 109:16

**taking** 76:22  
114:2

**talk** 58:5

**talked** 50:6

**talking** 55:13  
62:14 92:22,23  
129:7

**tangent** 36:9

**tangential** 36:11

**target** 63:2,5,7,10,  
18,23 64:2 73:16  
75:14 77:2 87:20,  
21 95:20,23  
120:13 125:7,10

**target's** 35:19

**task** 62:24

**taught** 19:17  
20:12,15

**teach** 19:15  
20:13,15 28:15  
29:5,12,16 30:9

**teaching** 19:14  
24:15 51:16

**team** 24:21,25  
25:2,4,6,8,11,14,  
17 70:18 72:4

**Teams** 14:14

**teens** 128:22

**telephone** 14:17,  
22 83:1

**telling** 30:9

**ten** 9:24 30:6  
49:12 51:25 52:5  
59:5 66:16 91:23  
111:18

**tend** 11:4 28:4  
39:8 52:23 56:19  
92:5,6,7 93:18,19  
103:8 131:5

**tendencies** 56:20

**Tennessee** 4:3  
5:6 44:9 54:3,9,  
13,18,22 61:2  
73:13 74:15,18,  
20,24 75:1,5,8,9  
77:4,9,17,21,25  
78:1,4,6 87:4,19  
113:13,19

**Tennessee's**  
73:12 113:8,10,23

**Tennessee.gov.**  
78:7

**term** 58:20 64:8,9  
70:4 80:20 93:1  
116:23

**terminal** 53:17

**terms** 12:12 14:21  
55:19 73:3 75:15,  
17 86:17 92:9  
122:2

**Terror** 106:23

**Terry** 4:24

**testified** 5:11  
12:22 25:24 40:10  
45:9,10,14,20  
48:21 70:23 79:4  
81:19 83:9 87:6

**testify** 10:13  
13:20 45:8,13,22  
46:5,7,9 119:22  
127:1,3

**testifying** 13:13  
115:22 126:24

**testimonies** 49:7

**testimony** 10:8,  
18 11:1,17,18  
12:5,16 13:5,9,23  
14:1 15:14,17,20  
17:3,15,16,18,25  
18:5,15 19:1  
36:14 45:6 49:6  
53:5 69:18 80:18  
84:15 100:10  
115:12 117:16  
118:1 119:21  
121:24 122:5,17

**tests** 22:2

**Texas** 5:15,17  
22:25 23:3,15  
24:19 26:21 81:22

**text** 18:10

**textbook** 123:12

**textbooks** 18:17

**texts** 18:10

**theoretical**  
111:21 125:11

**Theoretically**  
99:20

**There'd** 65:2

**thereto** 9:23

**thesis** 20:5

**thing** 55:10,24  
90:13

**things** 28:7,14  
32:22 39:11 40:4  
48:5 55:8 72:6  
122:15 129:24

**Thirty** 114:19

**thoracic** 90:12,  
16,18,20 91:4  
97:11

**thoracostomies**  
22:14

**thorax** 120:17

**thought** 71:20  
72:9

**thousand** 38:17

**thousands** 119:1  
121:22

**time** 9:5 21:13  
25:20 28:22 29:1  
30:3 33:15 42:1,2,  
18 45:4 47:19,20  
57:25 76:21 81:25  
82:12 83:5 93:18,  
22 94:21 95:5  
96:8 103:3 106:19  
109:16 111:24  
115:16 118:18  
119:5,16 120:7,  
14,20 122:21  
123:3 124:6 128:6  
129:20 132:7

**times** 5:23 14:22  
15:4 31:5 33:22  
34:15 52:4,5  
56:24,25 57:1  
59:18 60:9 94:1  
95:3 102:4,6  
103:21,22,23,24  
110:16 112:17  
117:11,17 118:12,  
17 121:17 122:9,  
12,18 124:6

**tissues** 66:7

**titled** 127:8

**TMA** 26:22

**today** 4:19 5:20  
7:21 10:8,19 11:1,  
17 13:9,19,23  
14:1 15:14,17,20  
17:3,15 18:5,15  
19:1 54:20 60:19

**toe** 12:1

**told** 57:21 69:10  
89:17 92:15,19  
93:8 100:9 118:17

**top** 16:14 37:17,20  
64:20 71:25  
127:16 129:13  
130:19

**topic** 9:23 12:9  
131:22

**topics** 40:20

**total** 18:12 51:11

**tough** 19:23

**toxicity** 57:9

**track** 124:7



**tracked** 119:8

**traditionally**  
22:20 131:7

**train** 25:8 76:17,  
18

**trained** 74:4,9,18,  
25 76:11,13

**trainer** 50:5

**training** 23:25  
24:2 28:14,15,18,  
19,20,21,23 29:2,  
4,6,22 48:10,13  
49:13,17,24 50:3,  
9,12,15 51:5,7,9,  
19 70:17 73:7  
74:13,16 75:2,9  
76:8,20 83:20,21

**trainings** 50:2  
51:13,20 75:4

**transfer** 22:5  
33:13

**transferred**  
33:11,15 34:23

**transmission**  
88:14

**trauma** 22:12  
32:15 37:2,7,8,9,  
12 52:12,13 83:23  
92:12 123:12,24  
124:5,12

**trauma-related**  
22:9

**traumatic** 57:4  
59:24 88:10 92:7

**travel** 105:14

**traveling** 88:13

**travels** 105:15

**treat** 25:14,16,17  
31:14 103:8  
129:10 131:7,9,  
10,16

**treated** 25:19  
31:25 38:14 40:1  
57:20 95:11  
102:1,4 103:10,19  
128:5,14,19

**treating** 34:22

**treatment** 22:2  
32:8 95:15 96:22  
131:14

**treatments** 23:19

**tremendous** 9:25

**trial** 10:22,23,24  
12:5 48:4 69:19  
115:17 127:3

**Tribunal** 126:6

**triple** 86:3 117:5

**trouble** 117:14

**true** 35:13 36:17  
65:12 68:12 77:19

**trunk** 63:16 65:2  
104:22

**trunks** 105:24

**truthfully** 13:20

**tubes** 22:13

**tunneled** 34:17

**Turley** 116:8

**turning** 76:23  
126:4

**Twenty** 119:2

**Twenty-five**  
103:23

**Twenty-one**  
86:15

**Twenty-twenty**  
46:11

**two-thirds** 64:17

**type** 37:13 62:6  
90:18 96:13,15  
103:5

**types** 91:7

**typical** 93:17  
97:21 98:5,6,9

**typically** 40:21  
66:16 93:17 94:18

---

## U

---

**U.S.** 78:21,24

79:2,18,21,25  
80:3,13,15,19  
81:1,2,3,5,23  
82:1,3 83:2 84:1,  
17 85:1,17 89:9  
95:22 101:12,16  
113:2 125:1  
127:8,22

**uh-huh** 11:1 44:1  
46:15,17 68:2  
94:12 111:17  
122:20

**ultimately** 9:17

**unable** 84:14  
107:3 121:14

**unclear** 50:24

**undergone** 48:10

**understand** 6:25  
69:18 99:17 112:5

**understanding**  
38:24 71:3 87:15  
98:18

**undertaken**  
72:11

**unintended**  
69:22

**unintentionally**  
71:11

**unique** 91:11

**unit** 17:8

**United** 76:23  
83:5,24 84:12,21

**universal** 76:2

**university** 18:23  
19:7,13,18 20:6,7,  
9,11,19,22

**Unlike** 119:7

**unprepared**  
119:25

**unsuccessful**  
122:1

**upper** 63:8,15  
106:4

**upset** 129:19,21,  
23

**Uptodate** 108:18

**username** 42:4,6,  
9,13

**Utah** 49:3 68:25  
70:24 71:1,5,7  
72:8,10,15,17  
79:1 80:21,25  
84:4,8 100:17  
101:2 110:7,14,  
17,22,25 111:3  
115:14,23

**Utah's** 78:19 79:8  
80:11 84:2 85:13  
86:14 95:20  
109:25 111:10  
112:5 124:18,25

---

## V

---

**vague** 116:23

**variability** 89:4

**variable** 88:23,24  
89:15,24 90:6,8  
91:9

**variance** 35:11

**variant** 35:8

**variations** 56:8

**varied** 56:8

**varies** 28:19  
76:19

**vary** 73:10

**vascular** 65:4

**vast** 76:25

**Vegas** 45:11

**vehicle** 57:5  
59:23 60:7,12,13

**vein** 105:3,18  
117:9 120:12

**veins** 65:6 104:19,  
22,25 105:4,6,7  
122:6

**vena** 65:5 104:23

**venous** 22:16  
65:4 104:24

**ventricle** 105:15,

18  
**ventricles** 63:15  
65:1  
**verbatim** 84:10  
**versus** 94:8  
117:21  
**vertical** 64:15  
98:10  
**vertically** 64:20  
**vessels** 56:12  
64:13  
**Victoria** 22:25  
**view** 12:14 72:1  
114:1,3  
**viewing** 69:5  
**views** 13:4,5  
**Vincent** 16:4,5  
**viral** 99:14  
**virtually** 36:24  
37:11 68:21 70:20  
**visibility** 125:18  
**Vitae** 8:9  
**volley** 110:3,13,  
15,18,19,23  
111:3,16,19,20,23  
112:8,10,11,13,  
15,20,23  
**volleys** 112:19

---

## W

---

**wait** 20:1  
**wall** 104:3  
**walls** 69:7  
**wanted** 17:14,25  
21:1 115:18  
**warden** 48:23  
49:2 115:22  
**Washington**  
127:12  
**water** 125:20  
**wave** 108:4,5

**ways** 114:4  
**weapon** 92:4  
**weaponry** 29:11  
**weapons** 57:9  
**website** 24:17  
40:14,17 77:25  
78:1,4,6  
**week** 115:17  
**weeks** 14:12  
17:11 77:22  
**Wellness** 23:19  
41:7  
**Welsh** 5:4  
**West** 23:3  
**wheelhouse**  
127:5  
**white** 94:4  
**who've** 39:7 57:4  
61:20  
**widely** 106:13  
**width** 98:5,7  
**wife** 67:24  
**Wildlife** 51:8  
**William** 19:4  
**Williams** 4:2,7,17  
5:9,14,19 6:16  
7:10 11:5 13:18  
19:3 21:6 26:2,20  
27:7 30:25 35:15  
36:14 37:25 38:14  
40:12 41:2 42:7,  
11 43:2,5,18,20  
50:19 51:4 52:14  
58:3 67:13 87:3  
89:5 91:24 94:10  
95:4 99:25 100:24  
101:12 102:1  
109:25 111:6  
114:23 115:8  
116:20 117:20  
119:19,20 121:18  
123:4,24 124:25  
126:4 127:6,25  
128:5,25 132:3  
**Winchester**  
96:18

**wind** 125:6  
**windows** 69:5  
**Wisconsin** 23:5  
24:20 27:21 28:7  
30:2,5,13  
**withdrawn** 85:6,8  
**witnessed** 59:16  
62:3  
**witnesses** 69:2  
72:2,3  
**women** 23:20  
128:10,12 130:11,  
15,17  
**wonderful** 56:8  
**wood** 71:6  
**word** 118:4  
120:13  
**words** 29:8  
112:12  
**work** 21:19 33:7  
71:25 72:1 114:22  
117:13  
**worked** 33:9 82:6,  
8  
**working** 66:10  
121:1  
**works** 67:5 82:6  
**world** 48:13 75:25  
83:7,8 94:4  
**worst** 117:15  
**would've** 111:25  
**wound** 12:18  
16:18,19 25:16  
31:3 32:5,10  
34:20 38:21  
39:10,13 41:25  
55:22,23 56:10,14  
57:11 59:6 66:21  
83:19 88:6,9,20  
89:10 90:10,15,  
18,19,22 91:16  
92:3,4,15 94:13,  
25 95:4 98:16  
99:11,15 103:10,  
14,16,17 104:2  
105:13 128:15,20,  
24

**wounding** 16:19  
40:22 41:24  
**wounds** 16:5  
25:15,18,22 32:25  
33:5 34:3,16,21,  
25 39:3,4,5,6,22,  
25 47:13 56:17  
57:16,17,19,22  
59:6 89:1,2 90:25  
91:2,7 92:1,4,5,6,  
8,9 99:1,4,18,21  
100:2,6,11 103:12  
112:1,2 119:7  
128:7,9,21  
**write** 40:13,20,21  
42:2 129:3 130:18  
**writing** 30:19  
101:3  
**written** 10:21  
16:16 84:15  
124:13  
**wrong** 13:11  
128:23  
**wrote** 17:5 75:20  
80:10 130:24

---

## X

---

**XY** 36:25

---

## Y

---

**year** 14:25 15:2  
19:9,13,22 20:17  
31:16,18 45:24  
46:7 47:3 51:11  
117:4 118:2,4  
**years** 9:25 19:17  
20:11,12 21:14  
24:16,24 25:1  
30:6 47:8,23  
49:13 50:15 51:25  
59:4 82:7,8 83:25  
84:19 117:2  
**Yesterday** 14:24  
**young** 108:21  
109:19 129:8,10,  
14  
**Young's** 108:15

**youngest** 128:19

**your-all's** 4:14

---

**Z**

---

**Zivot** 11:19 12:5,  
19,20,22

**Zivot's** 13:5

**zoology** 19:8

**Zoom** 4:20,25  
6:14,18